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DEFICIENCY DISEASES IN THE CINCINNATI GENERAL HOSPITAL

A Ten Year Study

Chairman's Address

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From time to time within the past decade medical publications have appeared describing patients in the Cincinnati General Hospital who were ill because of vitamin deficiency. In 1942 a statistical study revealed an incidence of pellagra in that hospital similar to that reported from New Orleans; Augusta, Ga.; Birmingham, Ala.; Durham, N. C., and from other southern cities where pellagra had been regarded as a common endemic disease. Our report in 1942[1] described an incidence which began in 1935 at 0.3 per cent of all medical admissions and rose each year to 1.5 per cent in 1938. Now it has been determined that since 1939 the incidence has gradually declined so that in 1947 and 1948 there were no cases of pellagra. A personal communication from Dr. Norman Jolliffe has described a similar situation at Bellevue Hospital, New York. It was believed that there had been only an apparent increase in the disease in the community incident to increased interest in the hospital. Now with the same circumstances which determine the admission of patients and with the same methods and zeal for diagnosis—and, in fact, the same individual physicians—there has been a notable decrease.

SCOPE OF THE STUDY

In a recent study which brought these facts about pellagra to print,[2] it was observed by the authors that the decline started before there was enriched flour or other concerted effort at dietary reform in Cincinnati. There was as elsewhere a change in business, employment and wages, the effects of which are profound but not directly measurable on the type of person furnishing most of the hospital admissions. Beriberi and also scurvy have been closely studied in the same period, but a similar decline has not been observed. Without attempting to explain why the incidence of deficiency diseases fluctuates in this manner, I propose herein to describe all of them that have been diagnosed in the past ten years, together with some of the medical, social and economic factors which, as I see them, may be concerned in nutrition and the public health. From 1939 to 1948, on a service which admits about 200 patients a month, pellagra has been diagnosed in 106 persons, beriberi in 48, scurvy in 33, riboflavin deficiency as cheilosis in 14, sprue in 4, vitamin A deficiency in 1 and vitamin D deficiency in 1. It cannot be stated how many of these patients were admitted solely for the deficiency disease which was eventually diagnosed. Many were admitted for a variety of other conditions, acute and chronic, and the deficiency disease was found to be a sequel or incidental to the other illness. During the entire period no special medical service such as a nutritional ward was maintained, and the continuous demand for hospital beds has made the admission of patients with minor though interesting forms of disease almost impossible. There has never been a routine laboratory test or screening method for case finding. The usual bedside clinical examination has been the method in continuous use for diagnosis, with laboratory devices used secondarily and for confirmation. Only cases observed on the medical wards are here described, although a few were discovered on other services in the routine of consultations. When treatment required it, the patients were transferred.

In vitamin B deficiency syndromes, house officers have considerable difficulty with the decision as to which of several diagnoses should be considered primary, or the leading cause for disability. In such dilemmas in which the two diseases, pellagra and beriberi, are present no patient has been counted twice in this study of incidence. However, some patients may on readmission have been found with a different disease—for example, scurvy.

The diagnosis of pellagra was established by observation of characteristic symmetric dermatitis, usually of the hands or feet, or both, and glossitis.

PELLAGRA

There were 106 patients whose disease was diagnosed as pellagra; 68 were white, 38 were Negro; 58 were men, 48 were women; the oldest was 84, the youngest was 20; the mean average age was 53.6 years; in 33 pellagra was caused by alcoholism; in 66, by some other disease, acute or chronic. These diseases were in the main of the same nature as those indicated in an article on secondary pellagra, published in 1944 in *Medicine*.[3] It should be restated now that there are no distinguishing features in various stages of the disease. Pellagra is pellagra, and at this hospital the term secondary pellagra is no longer used. Study

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Miss Ruth Roth, secretary of the Nutrition Council, Cincinnati Public Health Federation, provided data concerning the prices of specific foods and the cost of living index.

1. Bean, W. B.; Spies, T. D., and Blankenhorn, M. A.: The Incidence of Pellagra in Ohio Hospitals, J. A. M. A. **118**:1176 (April 4) 1942.

2. Bean, W. B.; Vilter, R. W., and Blankenhorn, M. A.: The Incidence of Pellagra in the Cincinnati General Hospital, 1935-1947, J. A. M. A. **140**: 872 (July 9) 1949.

3. Bean, W. B.; Spies, T. D., and Blankenhorn, M. A.: Secondary Pellagra, Medicine **23**: 1, 1944.

of these patients now throws no light on the pathogenesis of pellagra other than that observed in 1942. In only 16 patients could no cause for the disease be determined; hence it must be assumed that poverty and ignorance in matters of diet were the cause. Ignorance has proved a difficult etiologic factor to assess, qualitatively or quantitatively, but in the matter of dietary habits it has been determined that many patients prefer cornbread, fat meat and well boiled greens, as in so-called southern cooking. Of 106 patients, exactly 53 were born south of the Mason and Dixon line and were presumed to be accustomed to southern cooking. In this ten year period one half of all medical patients were born in the South. I believe the dietary habits prevalent in Cincinnati among those of southern origin have much to do with the high incidence of pellagra, but it is difficult to put the matter to a test.

Poverty is perhaps equally difficult to study. Cincinnati has it, but it is no worse than in comparable cities. During the ten year period employment and wages have steadily risen; so has the cost of food in almost parallel manner. Since many of our patients were unemployable, their poverty became greater as living costs became higher. The cost of all food rose from a price index of 95.2 in 1939 to 209.7 in 1948—120 per cent. The cost of greens, which may be considered essential to diet and may be chosen as a characteristic protective food, rose from an index of 0.045 to 0.135, or 200 per cent. Lean meat is equally important in the prevention of pellagra, and the cost of it certainly is a factor in its distribution and consumption. In Cincinnati the cost of lean meat (hamburger steak) has risen nearly 300 per cent in the same time that the incidence of pellagra has diminished. It is impossible to learn the actual consumption of these food items by the persons who are admitted to the Cincinnati General Hospital. A dietary history is taken in all instances, but this is unreliable except when done by an expert, who is not always available. It can be shown that in recent years it has become more difficult to buy pellagra-preventing foods than food in general. Enriched flour began to be used in this city in 1941, and, by 1943, 90 per cent of all the flour consumed was enriched.

Forty-four of the 106 pellagrins also had other specific deficiency diseases; for example, neuritis, cheilosis, vitamin A deficiency and scurvy. Many were found also with Wernicke's syndrome (presbyophrenia), hypertrophic or atrophic gastritis, hyperchromic anemia and hypoproteinemia—but these manifestations are considered essential to pellagra and therefore are not listed among the forty-four associated deficiency diseases. I do not include either delirium tremens or cirrhosis of the liver as an associated deficiency. There were only 8 patients with cirrhosis as an associated disease, which seems remarkable, because 33 of 106 pellagrins were chronic alcoholic addicts and had been on poor diets for a long time. In our 1942 report of collected literature cirrhosis was found to be a common cause of so-called secondary pellagra. Twenty-nine of the 106 patients died in the hospital, and 19 necropsies were performed. Altogether, complete study failed to disclose an obvious cause for death in 9 cases. It should be noted that none of the lesions of pellagra are, anatomically speaking, regarded as lethal. These 9 deaths were ascribed, then, to the prolonged and severe effects of malnutrition and to nothing else. In several cases the heart was enlarged rather than smaller, as is usual in cases of starvation. In none of this group had the diagnosis of beriberi heart been made, but it could not be excluded. Of especial interest are the 16 patients in whom chronic associated disease and/or alcoholism were not discovered; i. e., those who fell into poor dietary habits because of ignorance and poverty. Ten were born in the South. They had been long resident in Cincinnati and were comparable in age to the entire group. Four died and 3 were examined post mortem; all 3 exhibited no cause for death other than pellagra. The fatality rate, 27 per cent for this group of 106 patients, is necessarily high because of their associated diseases and chronic alcoholism. In cases of uncomplicated pellagra there were 4 deaths; i. e., a fatality rate of 25 per cent. This apparent failure of treatment was due to the severity and advanced stage of the disease, because nicotinic acid or nicotinamide were freely used in conjunction with good diet.

BERIBERI

The diagnosis of beriberi (neuritis due to thiamine deficiency) was made in 48 subjects exclusive of the patients with pellagra as the chief disease and berberi as an associated disorder. Of the 48, 45 were white, 3 were Negro; 34 were men, 14 were women; the youngest was 27, the oldest was 76; the mean average age was 53 years. Of the diagnostic criteria described by Aring and Spies,[4] absent or decreased tendon reflexes with tenderness of the nerve trunks and sensory changes were always observed. Few patients were paralyzed, and none remained paralyzed for long after treatment was started. Sixteen were found to have beriberi heart according to the criteria published by me in 1945 and again in 1947 in association with C. Vilter[5]: (1) enlarged heart with sinus rhythm; (2) dependent edema, (3) elevated venous pressure; (4) minimal electrocardiographic changes; (5) absence of all other causes of heart disease; (6) history of three or more months of a diet deficient in thiamine; (7) signs of neuritis or pellagra, and (8) recovery with decrease in heart size or observations at autopsy consistent with beriberi heart. Of the 48, 24 were classed as chronic alcoholic addicts and 19 as ill with other disease of a wasting nature, leaving 6 in whom no cause for the pellagra was discovered. Fifteen patients displayed other deficiency disease, and 4 had only cirrhosis. Nine had forms of cardiac disease other than beriberi heart. Eighteen died, a fatality rate of 37 per cent. Eleven necropsies were performed. In this as in the pellagra group, fatality rates were high because of severe associated disease, prolonged alcoholism and severe beriberi. Deaths from delirium tremens are not recorded in this group. In a number of instances no obvious cause for death was apparent; i. e., as morbid anatomy of gross nature. In some patients death was sudden and unforeseen. Vilter and I described patients in this group as subject to syncopal attacks and unexpected death.

SCURVY

Adult scurvy was diagnosed 33 times, with the criteria described by R. Vilter[6]: large cutaneous hemorrhages; hemorrhagic follicular keratosis and hemorrhagic gingivitis, and anemia, all of a type which

4. Spies, T. D., and Aring, C. D.: The Incidence of Neuropathy in Pellagra, Am. J. M. Sc. **199**: 840, 1940.

5. Blankenhorn, M. A.; Vilter, C. F.; Scheinker, I. M., and Austin, R. S.: Occidental Beriberi Heart Disease, J. A. M. A. **131**: 717 (June 29) 1946.

6. Vilter, R. W.; Woolford, R. M., and Spies, T. D.: Severe Scurvy, J. Lab. & Clin. Med. **31**: 609, 1946.

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are the classic signs of severe adult scurvy. Of the 33 patients, 31 were white and 2 were Negro; 29 were men, 4 were women; the youngest was 16, the oldest was 79; the mean average age was 61.5. Only 5 of the 33 were born in the South. There was chronic alcoholism in 5, associated disease in 13 and no known cause in 15. The associated diseases were similar to those described in association with pellagra. There were associated deficiency states, also principally due to lack of thiamine. There was but 1 patient with cirrhosis. Six died—a fatality rate of 18 per cent. It is notable that in 3 instances the cause of death could not be designated at necropsy. In each, beriberi heart could have been present but was not diagnosed because the usual criteria were wanting, but scorbutic hemorrhage was not the cause of death. A search of the social history in this group reveals that almost all of the patients were white men over 60 years of age who lived alone as recluses or on scanty income in a cheap lodging, where they did their own cooking. They were not especially addicted to alcohol, but they did not eat fruit or uncooked vegetables. There was no particular seasonal incidence (months). They were not habituated to southern diet. Many had not lost weight but had gradually become weak, mentally depressed and, eventually, confused; their neighbors or the police brought them to the hospital. The incidence of adult scurvy has risen from zero in 1939, 1940 and 1941 to an index of 0.38 in 1945. It has declined only slightly in 1946, 1947 and 1948, but not to the extent to which pellagra has. Meanwhile, the cost of citrus fruits has dropped 20 per cent from 1939 to 1948. It is obvious that the relative cost of avoiding scurvy has not increased but has indeed decreased. Meanwhile, the incidence has not declined as has that of pellagra. Associates and I are of the opinion that living habits are mainly responsible for the ill health of these persons.

OTHER DEFICIENCY DISEASES

Riboflavin deficiency is such a poorly defined disease that I shall give it but brief mention. The diagnosis was made on this service when a patient displayed angular cheilosis, conjunctivitis and a magenta-colored glossitis. This disease was diagnosed in 14 persons who were probably mildly ill with pellagra but were without symmetric dermatitis. Now with greater criticism or perhaps clinical skepticism, the disease either has become rare in Cincinnati or is ignored. The decision about magenta coloration is difficult; the conjunctivitis and cheilosis are not specific, nor do they respond specifically to treatment.

Sprue, vitamin A deficiency and vitamin D deficiency are so uncommon that they need only be listed as rare.

SUMMARY

Pellagra in the Cincinnati General Hospital has declined from an incidence in late 1930 and early 1940 of 1.2 per cent to a low of few or no cases in 1947 and 1948. The cause of this decline is obscure. It started before use of enriched flour became general and has continued despite the rising cost of food and especially the greater rise in the cost of greens and lean meat. The probable cause of the decline is dietary reform initiated by public health education and continued by the use of enriched flour. Pellagra occurred mainly in white persons, about equally in men and women. Assuming that poor diet is the cause, debilitating disease was contributory in more than half the cases, chronic alcoholism in a third. In 15 per cent of patients no cause for the disease other than a poor diet was discovered. One half of all pellagrins were born in the South and probably were accustomed to a diet low in thiamine and nicotinic acid. The fatality rate of the group was 27 per cent.

Beriberi occurred mainly in white men in the middle fifties and occasionally in women. Assuming that thiamine deficiency is the cause, chronic alcoholism was a contributary cause in 50 per cent and other disease in 37.5 per cent; the beriberi was without apparent cause in 12.5 per cent of patients. In 33.33 per cent there was beriberi heart. The fatality rate of the entire group was 37 per cent.

Scurvy occurred almost entirely in old men over 60 who lived alone or in lodgings. Chronic alcoholism and other disease were additional causes in less than one half. Dietary habit and poverty were the most frequent causes of the disease. The fatality rate was 18 per cent.

One half of the deficiency disease observed in the Cincinnati General Hospital was caused by other acute and chronic disease, and one third by chronic alcoholism. There has been decided reduction in the incidence of pellagra. This reduction is probably the result of dietary reform and the enrichment of flour. Beriberi has been reduced little and scurvy less.

ARTANE® THERAPY FOR PARKINSONISM

A Preliminary Study of Results in One Hundred and Seventeen Cases

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Trihexyphenidyl (artane,® 3-[1-piperidyl]-1-phenyl-1-cyclohexyl-1-propanol hydrochloride) is a member of a new series of antispasmodic compounds.[1] After intensive pharmacologic investigation [2] of its effects and of reactions to the drug in animals, the product was turned over to us for clinical evaluation. Its effects were carefully studied in a series of 117 cases of Parkinson's disease. (Since the preparation of the paper, the drug has been employed by us in some 150 additional cases with favorable results, but the observations were not available in time to be incorporated with the earlier cases.) Embodied in this report are the method of administration and use of trihexyphenidyl, correlated with the results of the therapy and the reactions of the patients.

The drug has been under study at several other clinics, and, although a detailed comparison of such data with our own has not yet been made, verbal reports are to the effect that other results fairly closely coincide with our own.

In an article published by one of us two years ago,[3] special attention was drawn to the need that exists for new preparations to be added to those regularly employed in the treatment of parkinsonism. The

Because of lack of space, this article has been abbreviated in THE JOURNAL by omission of the tabular data. The complete article will appear in the authors' reprints.

The investigation was conducted at the Vanderbilt Clinic, New York City, under the Department of Neurology, College of Physicians and Surgeons, Columbia University and Neurological Institute.

1. Cunningham, R. W.; Harned, B. K.; Clark, M. C.; Cosgrove, R. R.; Daugherty, N. S.; Hine, C. H.; Vessey, R. E., and Yuda, N. C.: The Pharmacology of Some Omega-Mono-Piperidene Tertiary Alcohols: New Antispasmodic Agents, J. Pharmacol. & Exper. Therap., to be published.

2. Artane® was developed by Lederle Laboratories, Division of the American Cyanamid Company.

3. Doshay, L. J.: Recent Trends in the Treatment of Parkinsonism, M. Rec. **160**: 339, 1947.

standard drugs to which reference was made include: scopolamine, stramonium, atropine, Bulgarian belladonna, rabellon® (a tablet containing belladonna alkaloids) and vinobel® (a tablet containing the alkaloids of belladonna root obtained by extraction with wine). In the light of this manifest need, the success which has attended the use of artane® is highly gratifying.

Parkinsonism has been an important and challenging problem to the neurologist for the past thirty years. Prior to 1918, parkinsonism was chiefly of the arteriosclerotic variety and as such did not pose too great a problem in terms of treatment, which essentially embraced hyoscine, stramonium and potassium iodide. However, the span of life has been materially lengthened in recent decades by the marvelous advances of medical science, so that we are becoming confronted with ever-increasing numbers of such cases.

In particular, however, the epidemics of encephalitis of 1918-1921 contributed a new and grave situation.[4] All efforts during the twenties were confined to the discovery of a vaccine that would successfully prevent encephalitis or check its course and symptoms. The effort failed.[5] Attention thereupon shifted toward the maximum exploration of various plant extracts to combat the symptoms of rigidity, oculogyria and tremor. It thus happened that Bulgarian belladonna was heralded with great promise in the thirties.[6] Although this drug failed to fulfil original expectations, it has nevertheless continued in use as a good adjunct in the treatment of Parkinson's disease, along with such other products as atropine and various alkaloids of belladonna.

During the past decade surgery made a strong bid for the relief of parkinsonism, but results thus far have proved sadly disappointing, because the determining site of the pathologic basis of tremor and rigidity remains unknown, rendering it difficult to know where and what to cut. Under the circumstances, it is not surprising that some surgeons operate on the subcortex, others on the lenticular nucleus or the pallidofugal tracts and still others on the spinal cord.[7] This ceaseless search to find relief for those who suffer with Parkinson's disease leads to the present era of synthetic drugs.

PHARMACOLOGIC PROPERTIES OF TRIHEXYPHENIDYL

Artane® is the trade name given to the synthetic product 275 C, which bears the structural formula of 3-(1-piperidyl)-1-phenyl-1-cyclohexyl-1-propanol hydrochloride and the generic name trihexyphenidyl. It was carefully tested, along with five other closely related synthetic products, for comparative determinations of their antispasmodic activities, pharmacologic effects and toxic reactions in relation to known drugs such as atropine and trasentin® (diphenylacetyldiethylaminoethanol hydrochloride). Six months of such experimentation with large numbers of various laboratory animals proved that trihexyphenidyl has greater antispasmodic qualities than any of the other five synthetic products and in this regard is twenty times as effective as trasentin® and half as effective as atropine. Similar to all antispasmodic drugs, the compound leads to cerebral excitation, but unlike the other five piperidyl derivatives it does not lead to convulsions, even under massive dosage. It has about half of the mydriatic and an eighth of the antisialogogue potency of atropine, and the inhibition of the cardiac vagus is only one-hundredth that of atropine. Lastly, it has no ill effects on blood pressure, respirations, blood cell count, kidneys, liver, metabolism of sugar, growth or reproduction in dogs, cats, rabbits, guinea pigs and rats. On the basis of the observations, it is evident that the compound possesses large elements of the favorable effects of atropine, without its dangerous components.

Use of trihexyphenidyl in the treatment of parkinsonism was suggested by an analysis of its pharmacologic properties in animals.[8] At this point we commenced trial of the product with our patients. By January 1948 its effects and reactions had been closely checked in some 20 patients with Parkinson's disease. Since then the series has rapidly expanded to include at present almost 270 cases, although for reasons previously stated we are reporting on only 117 cases, which have been followed most thoroughly and for the longest period.

METHOD OF ADMINISTRATION

Trihexyphenidyl was supplied in scored tablets of two sizes, 2 mg. and 5 mg., thus facilitating the administration in doses of 1, 2, 2.5 and 5 mg.

It was found that in postencephalitic parkinsonism larger doses are necessary than in arteriosclerotic or idiopathic forms of the disease. This observation was not unexpected, because the drug has properties similar to those of atropine, to which, according to common experience, postencephalitic patients present high tolerance.[9]

In mild and only moderately advanced cases one should start with a dosage of 1 or 2 mg. twice a day, increasing it to three or four times a day, as the condition and response of the patient warrants.

Since nearly all postencephalitic patients suffer from varying degrees of sialorrhea, it was found that antecibum administration was more effective among them. In cases in which tremor was the most disturbing symptom it was necessary to add a small dose of scopolamine to the trihexyphenidyl. In advanced cases, in which patients have become accustomed to large doses of other drug, we have at times found it desirable to start with half of a 5 mg. tablet of the compound two or three times a day, while reducing the high dosage of the drug which the patient has been taking and thus gradually changing over to trihexyphenidyl alone. Thus a patient has been changed not suddenly but gradually from Bulgarian belladonna or a proprietary alkaloid of belladonna to trihexyphenidyl. In postencephalitic patients with excessive sialorrhea and rigidity, small amounts of atropine solution may need to be added.[10]

Trihexyphenidyl has been used in the idiopathic group in approximately the same manner and dosage

4. Epidemic Encephalitis: Etiology, Epidemology, Treatment, Report of a Survey, the Matheson Commission, New York, Columbia University Press, 1929.

5. von Witzleben, H. D.: Methods of Treatment in Post-Encephalitic Parkinsonism, New York, Grune & Stratton, Inc., 1942, p. 52.

6. Alcock, N. S., and Carmichael, E. A.: An Investigation into the Treatment of Parkinsonism with Bulgarian Belladonna, Quart. J. Med. **7**: 565, 1938. Hill, D.: Bulgarian Treatment of Post-Encephalitic Parkinsonism: A Comparison with English Belladonna, Lancet. **2**: 1048, 1938. Neal, J. B., and Dillenberg, S. M.: Comparison of Belladonna and Other Forms of Medication in Treatment of Chronic Encephalitis, New York State J. Med. **40**: 1300, 1940. Neal, J.: Recent Advances in Treatment of Epidemic Encephalitis, ibid. **34**: 707, 1934.

7. Browder, J., and Meyers, R. A.: Surgical Procedure for Post-Encephalitic Tremors, Tr. Am. Neurol. A. **66**: 176, 1940. Bucy, P. C. and Case, T. J.: Tremor: Physiologic Mechanism and Abolition by Surgical Means, Arch. Neurol. & Psychiat. **41**: 721, 1939. Putnam, T. J.: Operative Treatment of Diseases Characterized by Involuntary Movements (Tremor, Athetosis), A. Research Nerv. & Ment. Dis., Proc. (1940) **21**: 666, 1942.

8. Harned, B. K., and Cunningham, R. W., oral communication to the authors.

9. Bremer, F. W.: High Atropine Tolerance in Post-Encephalitic Parkinsonism, Deutsches Arch. f. klin. Med. **149**: 340, 1925.

10. Doshay, L. J.: Moderate-Dosage Atropine Treatment of the Parkinson Syndrome, New York State J. Med. **42**: 1066, 1942.

as with postencephalitic patients. Since many of the former group have also some degree of sialorrhea, antecibum administration of the drug is likewise favored. By suitable adjustment of the dose to tolerance, these patients do well on the compound. Even so, the following rule should be adhered to in the treatment of all patients with parkinsonism: Since we have no cure for them, and there is none in the offing, the purpose of all available therapy should be to render the patient as happy, active and useful as possible. Hence, it is never wise to force a new remedy on a patient who is content with his present regimen of treatment.

The drug is effective in the arteriosclerotic group in smaller doses than in the postencephalitic. Many patients are comfortable on a dosage of 1 mg. two or three times a day. The dosage can then be raised gradually to the optimum level for the particular patient. Since sialorrhea is not so often a factor in the arteriosclerotic type, the drug is better administered post cibum. If the patient is especially sensitive to the drug, one 2 mg. tablet may be broken into pieces and administered over a period of several hours in the day. If tremor is pronounced, it may be necessary to supplement the compound with small amounts of scopolamine, but seldom is it necessary to add belladonna for this age group. Use of atropine is contraindicated among these older patients. In some arteriosclerotic patients as much as 10 to 15 mg. of trihexyphenidyl may be necessary to provide the desired results; even this amount is well tolerated.

Physical therapy is a most valuable adjunct to the use of the compound. With his general sense of well-being improved by the drug, the patient becomes more amenable to the suggestion that he make the most of his improvement by accepting the additional help which can be derived from consistent and regular passive and active muscular reeducation. In fact, those patients who have profited most from the drug and who have maintained their level of improvement and continued to improve have as a general rule been those who were able and willing to supplement the medical regimen with various forms of physical therapy and exercises.

No special precautions are necessary in the administration of trihexyphenidyl. Our experience has been that it is an unusually mild drug, overdosage of which is almost impossible. It works its benefit without noxious side effects. It will be shown that the side reactions from the use of the compound are minimal, as compared with those of other drugs employed in the treatment of parkinsonism. The reactions seldom become disturbing to the patient, and they tend to wear off with continued use.

Though the usual dosage is between 6 to 10 mg. a day, 15 to 20 mg. is easily tolerated and doses of 30 to 50 mg. have not had deleterious effects. Complete blood cell counts in over 50 per cent of the 117 patients who were studied failed to reveal abnormal changes.

The presence of hypertension, cyanotic induration of the liver or renal disorders does not contraindicate the use of the drug, as the following case will illustrate:

CASE 1.—A. K., a man aged 59, had a tremor in his left arm when he was 50 years of age. The syndrome progressed rapidly; the left side became rigid, followed by involvement of the right extremities, neck and trunk. There was some drowsiness and sialorrhea. He spoke in a monotone. There was no diplopia, strabismus, weakness of convergence, nuclear palsy or oculogyria. The clinical picture was typical of idiopathic parkinsonism. Over a period of years he was maintained at first on small amounts of atropine and later on Bulgarian belladonna, rabellon,® scopolamine and vinobel.® He would remain stationary for long periods, with minor fluctuations in his condition. He was able to get about slowly, although he required help with dressing. On rare occasions he would smile, but for the most part he remained disgruntled, irritable and depressed.

At the age of 55 years there developed otosclerosis and gradual evidence of cerebral and generalized arteriosclerosis. Albumin and casts appeared in the urine, and his blood pressure rose to 200 mm. systolic. He began to complain of headache, vertigo and tinnitus. Edema of the ankles and legs developed, necessitating the recurrent administration of intravenous mercurial compounds. For the past four years he spent the winters in Florida.

In December 1947 belladonna and scopolamine were discontinued by a local physician, with the result that the patient became, as his family described it, "stone rigid" and was unable to chew, swallow or speak. He was then placed in a mental institution, where he was fed fluids intravenously, lost considerable weight and was considered moribund.

At this point he was placed on trihexyphenidyl therapy, 2 mg. three times a day. There was almost immediate improvement. He began to eat, talk and smile. He soon progressed to dressing and shaving himself. He gained weight and seemed a changed man. He was admitted to the Neurological Institute in April 1948 for a short period of observation and was found to be much improved over his condition of a year before. On examination, no pyramidal signs were found but there was a slight increase in the Achilles tendon reflex on the left. There was no drowsiness. His expression was good and his eyes alert; the bilateral tremor of the year previous, as well as rigidity with cogwheel movements, were all definitely diminished. In May 1948 Bulgarian belladonna was added to the medical regimen, and to date this dosage has not needed to be increased.

The most profound change in the man has been his mental improvement. Previously, because of tenseness and restlessness, he could not maintain any position for long and continually demanded that his legs and arms be stretched and his position changed. He berated his family for lack of sympathy and complained of constant pain and suffering throughout his body. He moaned, cried and was full of self pity.

Under trihexyphenidyl therapy his mental attitude became entirely different. He was able to sit quietly, calmly and fairly relaxed for hours at a time. He was again able to eat at table with his family and complained no longer of pains in muscles and joints. There has been no more groaning or crying.

The effect of the drug in this case was obviously not due to a reversal of the original pathologic conditions, but to a symptomatic change in the bodily and mental expression of the basic disease. Nevertheless, temporary and supportive as this treatment may be, it brings great relief to a patient suffering from a chronic progressive disease.

The distinguishing clinical features of the three essential types of parkinsonism, postencephalitic, idiopathic (formerly and erroneously called paralysis agitans) and arteriosclerotic, are so well differentiated and simple to recognize that they should be familiar to every one, especially since patients belonging to these groups differ in their response and reaction to drugs. A summary of the distribution of the salient symptoms characteristic of the three types of parkinsonism enables one to visualize the diagnostic criteria that characterize each group.

THERAPEUTIC EFFECTS OF THE DRUG

There were 75 men and 42 women in the series under study, with the youngest among them 25 years of age and the oldest 78. Although it is a common observation that patients with parkinsonism tend to tire of any remedy and to engage in an endless search for

something better, it was encouraging to find that 80 per cent of the patients who have been placed on trihexyphenidyl therapy have continued it month after month, without desire to change to another drug and without expressions of dissatisfaction.

In order to abstain from rough estimations of precise degrees of improvement, it was considered advisable to employ only the two categories of "improved" and "unimproved" to express our results. Patients were classed as improved if the symptoms were lessened to any appreciable degree or if the patient's comfort and well-being were bettered. If the patient derived no relief or expressed a desire to change to another medicament he was classified as unimproved. Since there were no patients actually retarded by the treatment, there was no basis for employing the designation "made worse."

Parkinsonism is a chronic progressive disease, and experience teaches that one is not justified in utilizing minute shades of change to record the results of treatment, such as near cure, remarkably improved, much improved, moderately improved and slightly improved. Besides, in many of the so-called "near cures," in which initial effects of the drug appear remarkable, improvement tends to lessen with time. Moreover, on discontinuation of the treatment all benefits cease. It is desirable, therefore, in reporting the value of any treatment in such chronic and long-continued illness, to refrain from overenthusiastic conclusions based on one small cross section of time. Therefore, although almost unbelievable improvement was obtained with the compound in many instances, it was considered desirable to classify even these patients under the unmodified designation of "improved."

It will be noted that 76.1 per cent of the patients treated with the drug were improved and 23.9 per cent unimproved.

Although the figures alone are most gratifying, they hardly serve to convey the full measure of benefits which patients derived from use of the drug. For this, we shall briefly cite some case histories that were not specially selected but taken from a small alphabetic list of patients receiving the compound.

Case 2.—B. G., a woman aged 55, had acute encephalitis in 1928. This was followed by slowly progressive rigidity, slight tremor and lethargy. In 1945 curare was tried at Duke University with little effect on the rigidity. She tolerated scopolamine and stramonium poorly and in August 1947 was started on trihexyphenidyl therapy. She moves more freely, drives her car, looks brighter, is less depressed, swallows more easily and has gained weight. Her improvement continues satisfactory ot date.

Case 3.—C. G., a man aged 34, noted the development of progressive stiffness and some tremor in the course of the last four years. There was no available history of a preceding acute illness. Examination revealed slight strabismus, weakness of ocular convergence and lethargy. He had been treated with various belladonna preparations. On trihexyphenidyl he has obtained improvement. He is more cheerful; the rigidity is less; his speech is clearer, and he is generally more alert and active.

Case 4.—L. G. is a man aged 47 whose postencephalitic parkinsonism symptoms started in 1932 and progressed to an advanced state of rigidity and tremor, torticollis, lethargy, sialorrhea and oculogyria. In 1943 he underwent cerebral surgery without improvement in his rigidity or tremor. In fact, the latter had become worse so rapidly that massive doses of scopolamine were necessary to afford the patient some temporary relief. In January 1948 trihexyphenidyl therapy was begun, and he gradually discontinued the use of all scopolamine. The tremor has lessened, and the oculogyric crises have ceased.

Case 5.—M. G., a man aged 62, had tremor and rigidity of three years' standing. He had been receiving the usual medicaments for this age group. In March 1948 he was placed on trihexyphenidyl therapy, and it has made him happier than all previous treatment measures. He eats and sleeps well; he walks easier, and the tremor is less.

Case 6.—R. G., a man aged 44, had encephalitis in 1918, followed by increasing rigidity, tremor and oculogyric crises. He had been under the care of the Matheson Commission for the study of encephalitis in 1929 and had received encephalitis vaccine and most of the other known forms of treatment. He was placed on trihexyphenidyl therapy in January 1948, with the result that he is more cheerful than he has been in years and has few oculogyric crises. The tremor is slightly less, and he moves easier.

Case 7.—R. G., a woman aged 63, had progressive tremor and rigidity of four years' standing. Scopolamine and belladonna produced dizziness, drowsiness and general weakness, so that she had discontinued all medicaments the previous year. In June 1948 she was given the new drug. She walks easier, feels better mentally and has little tremor.

Case 8.—S. G., a man aged 40, in 1939 noted the development of stiffness in the right arm. This was followed by tremor, increasing rigidity, sialorrhea, impaired speech, depression and thoughts of suicide. He has been receiving the compound for seven months, with little change in the physical symptoms, but his nervousness and tremor have subsided. He is calmer and more relaxed and partakes of a busy program of activities.

Although parkinsonism is a chronic progressive disease, it must not be assumed that the course is of necessity always rapidly or steadily downhill. There are patients who under suitable treatment remain stationary for as long as ten or fifteen years, as the following case illustrates:

Case 9.—G. K., a man aged 40, had an acute attack of encephalitis in 1929 at the age of 19, and shortly afterward there developed rigidity of the muscles of the neck and arms and periodic attacks of oculogyria. These became so frequent that he feared the loss of civil service employment. Early in the course of his illness scopolamine and stramonium had been tried and failed to bring any relief. On atropine, however, which he had been taking for the past twelve years, there was complete control of the oculogyric crises and a regain of freedom of bodily movement, with a lessening of spasticity. His improvement continued until 1947 when, despite increases in atropine dosage, the oculogyria and body rigidity returned in severe form, so that he was forced to give up employment. Trihexyphenidyl was prescribed in the Spring of 1948 and brought him some measure of relief. However, it did not materially alter the recent rapid progress of the symptoms. Parpanit® (diethylaminoethyl-1-phenylcyclopentane-1-carboxylate hydrochloride), diethazine hydrochloride (diparcol,® diethylaminoethyl-thiodiphenylamine) and other nerve preparations proved equally ineffectual.

The explanation for the period of twelve years in which the patient's disease remained in status quo is not attempted. Obviously, atropine could not be responsible for a reversal of pathologic processes in the interstitial nucleus and substantia nigra. It could, however, have modified the effects of the pathologic condition on the peripheral structures and exercised a stimulating action on the prefrontal cortex, so that the progress of the disease seemed to be stopped for a long time.

The reappearance of symptoms after an interval of twelve years may have been a sudden advance in pathologic changes or the result of increased tolerance of the body tissues to the drug, with loss of its long beneficial effect. Because it is the general experience that the effects of drugs do tend to decrease with use, the need for ever new and more effective medicaments

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is granted. In the long drawn out course of parkinsonism, patients regularly tire of one drug after another, so that it becomes necessary for the physician to have his armamentarium continually renewed. Also, one finds that some patients tolerate better one drug, others another. Atropine, for example, while a valuable med-

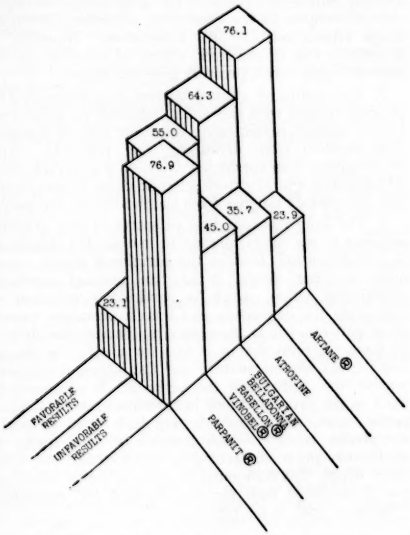

Chart 1.—Percentages of favorable and unfavorable results among different preparations employed in the treatment of parkinsonism.

icament in many cases of postencephalitic parkinsonism, is unsafe in the older arteriosclerotic group, because of the hazard of precipitating glaucoma and other disturbing circulatory and visceral phenomena.

Trihexyphenidyl, with its similarity to atropine but without the toxic side reactions of the latter, has proved a valuable adjunct in the treatment of arteriosclerotic parkinsonism and of the idiopathic variety. A favorable response to treatment has been observed more frequently among members of these two groups than among the postencephalitic patients. Chart 1 shows that the drug afforded as much symptomatic relief to sufferers with parkinsonism as did any other available drug.

In addition to the physical improvement, the mental stimulation which the compound affords has served to successfully counteract impatience, discouragement and depression, which are common byproducts of any chronic illness. Many patients receiving trihexyphenidyl were able to carry on with their work better and with more feeling of satisfaction, whether laborer, housewife or shopkeeper. The women found their household chores easier. Rigidity was improved, and tremor and oculogyria were either controlled or lessened. Even patients with advanced symptoms of twenty years' duration were helped greatly by being made more comfortable and able to assume some care of their persons, which previously had become the responsibility wholly of their families or caretakers. In this respect the drug is of more extensive value than atropine, which is of benefit to persons with early postencephalitic manifestations but far less helpful to those whose disease is of long standing.[11] Trihexyphenidyl, in contrast, proved almost as beneficial to postencephalitic patients with over ten years' duration of illness as to those with more recent symptoms (72 per cent; 75 per cent).

UNTOWARD SIDE REACTIONS OF THE DRUG

Experience with the use of various drugs in the treatment of parkinsonism proves that patients react differently to any given drug, depending on the type, duration and degree of illness and the age, temperament, mental attitude and constitutional makeup of the patient. Thus, it is common observation that some patients disregard dryness of the mouth or try on their own to relieve it by simple means, while others complain so bitterly that it becomes an obstacle in the treatment.

Atropine, for example, which produces pronounced dryness as well as complete cycloplegia, is tolerated well by postencephalitic subjects, who generally suffer from appreciable sialorrhea. In fact, many of these patients measure the merits of any drug by its drying effect. The compound being studied produces minimal dryness (actually 12 per cent that of atropine), and only 14 of the 117 patients brought complaint on this account. Our experience has been that 90 per cent of all patients will manage to counteract or disregard a moderate amount of dryness and blurring of vision, if these are not accompanied with more disturbing types of reaction. For a summary of the mild as well as the disturbing types of reaction from this and other drugs, see chart 2.

Nausea and vomiting may be danger signals of idiosyncrasy or approaching toxicity, but they may be

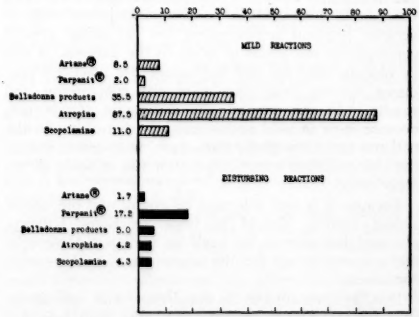

Chart 2.—Percentage of mild reactions (dryness of mouth and blurred vision) and disturbing reactions (dizziness, tachycardia, prostration, nausea and depression) among different drugs employed in the treatment of parkinsonism.

caused by psychic factors, food dyscrasias or gastrointestinal infection. Moreover, some patients will experiment on their own with larger quantities than prescribed or with additional drugs. Nevertheless,

11. Doshay, L. J.: Graphic Rigidity Index, J. Mt. Sinai Hosp. 5: 451, 1938.

until another cause for the symptoms has been determined, nausea and vomiting should regularly be considered serious and administration of the drug should be discontinued, or the dosage reduced, until better tolerance is effected.

Atropine is the only one among the standard drugs which causes disturbing gastrointestinal symptoms. One case of vomiting was encountered among the 117 patients on trihexyphenidyl therapy, and this was of only moderate degree and occurred in a patient with psychiatric symptoms.

Giddiness or dizziness is usually the result of sudden circulatory disturbance or fall in blood pressure, in reaction to a drug. It is most apt to occur among arteriosclerotic persons. Although the patient often becomes greatly alarmed by the symptom, there is actually no danger. Nevertheless it is an indication for reduction of medication. By the same token, tachycardia is a distressing symptom to some patients. Since it is usually disregarded and unreported by the younger persons with postencephalitic disease, it appears with comparatively greater frequency among the older patients. Tachycardia did not appear among any of the subjects receiving artane.®

Adynamia, or prostration, is a reaction, caused by the curare-like effects of a drug, which is of disturbing proportion to older patients. It is often accompanied with a large psychic component, with the patient complaining that he felt "paralyzed" and powerless to move for days at a time. Mental depression is listed as a reaction among patients, when they become unduly agitated and depressed by one or more of the foregoing unpleasant side effects of the drug, or when they become discouraged by the failure of results from a given therapy.

Aside from these, it can be safely stated that all other reactions deriving from the use of the standard drugs are sufficiently mild to constitute no hazard to the health and welfare of the patient. However, since the aim of treatment in parkinsonism is not only to achieve physical improvement but to bring greater contentment and peace of mind to the patients, it will be obvious that the less unpleasant the reactions produced by the drug the better the cooperation and results. In this respect the compound stands out, because it is so mild and so slightly disturbing to the patients that they gladly turn to it, in order to escape the side reactions experienced after use of some of the other drugs.

Because it is well tolerated by young and old and is almost entirely devoid of toxic reactions, trihexyphenidyl has earned for itself an undisputed place in the armamentarium for the treatment of parkinsonian conditions.

Finally, it remains to be noted that, with due allowance for the disappointments in results with vaccines, plant extracts and surgical measures, synthetic drugs have at long last come to the fore to bring hope and promise to those who have parkinsonism. Trihexyphenidyl, a synthetic drug, has been proved in this study to be able to do as much and more for these patients, than all existing forms of treatment. On this basis rises the prospect that in the near future still more and better synthetic preparations will become available, which may ultimately spell complete relief from tremor, rigidity and oculogyria.

SUMMARY

1. Trihexyphenidyl (artane,® 3-[1-piperidyl]-1-phenyl-1-cyclohexyl-1-propanol hydrochloride) is a new synthetic, antispasmodic drug for the treatment of parkinsonism.

2. Extensive pharmacologic tests with laboratory animals proved that action of the drug mildly resembles that of atropine in the control of sialorrhea, in cycloplegic effects and cerebral stimulation. However, it is entirely free of the toxic effects of atropine on the cardiac vagus, blood pressure and circulation.

3. The results of clinical studies in a series of 117 patients treated with this agent, establish its great usefulness against parkinsonian disorders and its remarkable freedom from disturbing side reactions. The investigation was conducted with 47 postencephalitic, 33 idiopathic and 37 arteriosclerotic cases of parkinsonism, for periods ranging from six months to two years.

4. The drug was found on all scores to be a valuable addition to the drugs already in use for the treatment of parkinsonism. Besides the peripheral effects, common to other drugs, it has an unusual cerebral-stimulating action, which is particularly effective in combating the depression and inertia prevalent among these patients. It is, moreover, so remarkably devoid of toxic reactions that it is safe for use by the young and the old, the ambulatory and the infirm, the hypertensive, the cardiac and the nephritic. It recommends itself as the drug of choice in arteriosclerotic and idiopathic cases, and should be regularly tried in postencephalitic cases in which atropine or other forms of medication prove disturbing or ineffectual. As with other drugs, this compound is more effective when its use is combined with physical therapy and exercises.

700 West 168th Street (32).

PAROXYSMAL COLD HEMOGLOBINURIA ASSOCIATED WITH DEMENTIA PARALYTICA

Report of Treatment with Penicillin

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and
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Paroxysmal cold hemoglobinuria is a syndrome characterized by the intravascular hemolysis of red blood cells and the excretion of hemoglobin in the urine following exposure to cold. It is one of the rarer complications of late syphilis. Less than 300 cases were found in the literature[1] up to 1932, and since that time only 40 additional cases have been reported.[2] In most instances this condition occurs in patients with latent syphilis, either congenital or acquired.

In this syndrome the intravascular hemolytic reaction is dependent on the presence in the serum or plasma of a hemolysin, which is absorbed by the red blood cells only at low temperatures. Complement is not necessary for this phase but is essential for hemo-

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1. McCarthy, F. P., and Wilson, R., Jr.: Paroxysmal Hemoglobinuria: Report of Cases with Familial Findings, New England J. Med. **207**: 1019-1022 (Dec. 8) 1932.

2. (*a*) Becker, R. M.: Paroxysmal Cold Hemoglobinurias, Arch. Int. Med. **81**: 630-648 (May) 1948. (*b*) Fleming, R. G., and Heffner, B. L.: Paroxysmal Cold Hemoglobinuria: Report of Two Cases, North Carolina M. J. **9**: 142-145 (March) 1948.

lysis to occur when the body is rewarmed (the Donath-Landsteiner reaction). The serum of patients with paroxysmal cold hemoglobinuria will hemolyze the red blood cells of other persons in the same blood group, but the erythrocytes of patients with this condition are not lysed by the serum of normal persons. This hemolysin is distinct from the Wassermann reacting substance (that is, reagin), and there is no correlation between the titer of the complement fixation or flocculation tests for syphilis and that of the hemolysin, except that both usually decrease following antisyphilitic therapy.

Evidence that this disease is caused by syphilis seems well established, but the mechanism remains obscure. The coexistence of active clinical syphilis and paroxysmal cold hemoglobinuria are uncommon. The finding of the Donath-Landsteiner hemolysin in patients with late syphilis has varied from less than 0.2 per cent to 20 per cent.[3] In a study by Donath and Landsteiner of 93 patients with dementia paralytica, only 1 patient was found to have paroxysmal cold hemoglobinuria but 6 others had a positive Donath-Landsteiner reaction without clinical manifestations of hemoglobinuria.[4]

The following case seems worthy of reporting because of the rather unusual association of dementia paralytica and paroxysmal cold hemoglobinuria. This is the third reported case of paroxysmal cold hemoglobinuria treated with penicillin.

REPORT OF CASE

History.—J. T. E., a white mechanic aged 48, was admitted to Grady Memorial Hospital Oct. 22, 1948 for treatment of early dementia paralytica. At the age of 32 the patient had a penile lesion which was diagnosed as syphilis by his family physician, who treated him with seven or eight injections of an arsenical preparation. There was no subsequent treatment or serologic test for syphilis until the present admission. Approximately seven years before admission the patient noted the onset of severe shaking chills after exposure to cold. This was followed by fever, sweats, nausea, dizziness and the passage of dark urine. The patient attributed these symptoms to an old back injury. He also experienced blanching and numbness of his fingertips and ears but noted no evidence of urticaria. These attacks occurred every winter and were so severe that the patient was often too weak to work. Following these episodes, jaundice of several days' duration was frequently noted. The patient soon learned that he could not go outside in cold weather, sit in a draft, bathe in cool water or otherwise be exposed to cold without precipitating these symptoms. His last attack was in the winter of 1947-1948. He had had no attacks during the cold months preceding this hospitalization, because he feared to venture outside and had remained in the house during cold weather.

Approximately five months prior to admission the family of the patient noted that he had become nervous, weak and forgetful. These symptoms progressively increased before admission, and he was observed to have extreme emotional lability and an undue concern over trivialities. He experienced episodes of confusion and on several occasions awoke at night and was disoriented for a short period of time. The patient himself demonstrated signs of anxiety and felt that something was wrong, but he was unable to describe the cause of this fear. There was no history of headaches, paralyses or convulsions. The remainder of his past history was unremarkable. The wife of the patient denied having had syphilis, and her serologic test for the disease was negative.

Physical Examination.—On physical examination the blood pressure was 150 mm. of mercury systolic and 80 mm. diastolic; the temperature was 99 F., the pulse rate 110 and the respiratory rate 24. The patient was a well developed and moderately obese white man. He appeared to be neatly dressed but was extremely anxious, grunting and moving his hands and feet restlessly. The pupils were small but equal and reacted sluggishly to both light and accommodation. The ocular fundi appeared normal. Ears, nose and throat were normal. There was no enlargement of the superficial lymph nodes. The size of the heart appeared to be within normal limits, and there were no murmurs. The lungs were clear to percussion and auscultation. The abdomen was obese, and no organs or masses were palpable. The genitalia were normal. The reflexes were hypoactive but equal bilaterally. Pain, touch, position and vibratory sensations were normal. There were slight, continuous tremors of the hands, lips and tongue.

A mental status examination showed the patient to be slightly depressed, and quite concerned about his illness, without delusions or hallucinations. The patient was oriented as to place but confused as to the day of the week, the month and the year. There was some impairment of his objective memory for both recent and past events. His fund of knowledge was somewhat limited. He was able to repeat four digits, though slowly. Only the simplest type of calculation was possible. There was some slurring of the test phrases and his handwriting was tremulous.

Laboratory Data.—Laboratory examination on admission revealed 3,900,000 red blood cells per cubic millimeter, a hemoglobin level of 11 Gm. per hundred cubic centimeters, and a white blood cell count of 5,800 per cubic millimeter with a normal differential. His blood was type A, Rh positive. The sedimentation rate (Westergren) was 30 mm. in sixty minutes; the nonprotein nitrogen 47 mg., total serum protein 6.7 Gm., cholesterol 188 mg. and the serum bilirubin 0.2 mg., per hundred cubic centimeters. Urinalysis was normal. The urinary urobilinogen was within normal limits. Reaction to the serologic test for syphilis was positive with 10 Kahn units. Tests for cold agglutinins were negative. Examination of the spinal fluid revealed normal pressure and dynamics, 62 lymphocytes per cubic millimeter, 1 plus Pandy reaction, protein 56 mg. per hundred cubic centimeters, a 4 plus reaction to the Wassermann test with 0.0312 cc. of spinal fluid, and a mastic reaction of 443211. The red blood cells did not exhibit increased fragility. Ehrlich's test and a Mackenzie "rough" test (which is described later) were both positive. Since the patient showed hemoglobinemia with Ehrlich's test, a Rosenbach test was not considered advisable. Tests were not made for the presence of dermolysins. The Donath-Landsteiner test was positive with a 1:2.5 dilution of serum. An electrocardiogram and teleoroentgenogram of the chest were interpreted as normal.

Treatment and Course.—The patient was treated with 60,000 units of penicillin G in aqueous solution every three hours, intramuscularly, for a total of 4.8 million units. He exhibited a mild Herxheimer reaction in the first twenty-four hours after the onset of treatment, with a rise of temperature to 101.2 F. but without aggravation of clinical symptoms. The patient's hospital course was otherwise uneventful, and some clinical improvement was noted at the time of discharge from the hospital on Nov. 9, 1948.

Following hospitalization, the patient has been observed at monthly intervals up to the present. One month after discharge from the hospital he was cheerful and better oriented; he showed some return in memory and in his ability to perform simple arithmetical calculations. The patient had not had chills or episodes of hemoglobinuria, though he had been out in freezing weather on several occasions. Six months after treatment, the patient's mental status appeared to be entirely normal. His wife believed that he had become completely well. A spinal fluid examination revealed 3 lymphocytes per cubic millimeter, 32 mg. protein per hundred cubic centimeters, a positive Kolmer reaction with 0.1 cc. of fluid and a normal mastic test.

There had been no further manifestations of hemoglobinuria. Ehrlich's test was still positive six months following discharge from the hospital, but there was no clinical reaction following a Rosenbach test. The Donath-Landsteiner test had not significantly changed since his admission, being positive in a 1:1 dilution of serum. Definite hemolysis was still present

3. Ross, J. F.: Hemoglobinemia and Hemoglobinurias, New England J. Med. **233**: 691 (Dec. 6) 1945.
4. Mackenzie, G. M.: Paroxysmal Hemoglobinuria: A Review, Medicine **8**: 159-191 (May) 1929.

with this concentration of serum, but the reaction required lower temperatures (4 to 10 C.). On admission of the patient the Donath-Landsteiner test had been positive at temperatures of 18 to 20 C.

COMMENT

This patient showed almost complete recovery from symptoms of paroxysmal cold hemoglobinuria and dementia paralytica within a short time following treatment with penicillin. The symptoms of hemoglobinuria had been present for seven years and were rather incapacitating, while mental changes had been noted for only about five months before treatment.

The clinical manifestations of paroxysmal cold hemoglobinuria vary in intensity but follow the same general pattern. Following exposure to cold, the patient soon experiences prodromal symptoms of malaise, muscular aches and pains, abdominal cramps, headaches, nausea and vomiting. Certain patients manifest vasomotor disturbances such as urticaria, fluctuating blood pressure or Raynaud's phenomenon. Shortly after exposure to cold, the patient experiences a shaking chill, the severity of which is dependent on the degree of hemolysis. The patient's temperature may rise to 102 or 104 F. If large numbers of red cells are hemolyzed the patient may be definitely jaundiced for several days. Attacks may leave the patient with weakness, lassitude and mild nausea. The liver and spleen are occasionally palpable during the attack.

One to four hours after chilling, the urine becomes dark red, wine or mahogany in color. It frequently contains albumin, casts and even a few red blood cells. Spectroscopic examination reveals the color to be due to oxyhemoglobin, methemoglobin and sometimes hematin. The red blood cell count and hemoglobin content may drop decidedly following an attack. An initial neutropenia occurs during the exposure to cold, followed by a leukocytosis in the chill phase. The blood serum is colored pink or red, and in severe cases the serum bilirubin level may be elevated. The serologic test for syphilis is almost always positive. If the patient has persistently negative tests for syphilis the diagnosis of paroxysmal cold hemoglobinuria should be questioned.

The majority of patients with paroxysmal cold hemoglobinuria usually manifest a positive response to Ehrlich's test. This test consists of binding the finger with a ligature and immersing it in ice water for a few minutes. After the finger is warmed, local hemoglobinemia can be demonstrated. This reaction is less hazardous than the Rosenbach test and is preferable in the investigation of patients with hemoglobinuria. The Rosenbach test consists of immersing the hands or feet in ice water for ten to twenty minutes. The resulting hemolysis may produce severe constitutional symptoms and has occasionally resulted in anuria. Repetition of the cold water test may cause sufficient depletion of the patient's complement that negative reactions are obtained.

The Mackenzie "rough" test consists of chilling a sample of the patient's blood in ice water. A positive test is denoted by hemolysis after the blood is rewarmed. In the Donath-Landsteiner test a mixture of the patient's red cells, varying dilutions of his serum and guinea pig complement is immersed in ice water and then rewarmed. Hemolysis of the patient's cells is noted in a positive test. Appropriate controls are necessary for the interpretation of both these tests.

Differentiation from other common types of hemoglobinuria is usually relatively simple. In the Marchiafava-Micheli syndrome the hemoglobinuria occurs only at night. March hemoglobinuria occurs only after considerable physical exertion, such as after forced marches by soldiers. The Donath-Landsteiner reaction is negative in both these conditions. Paroxysmal cold hemoglobinuria must also be differentiated from that caused by cold hemagglutinins. In this condition hemolysis occurs while the blood is immersed in the ice water, and rewarming is not necessary for hemolysis to occur. Stat's work indicates that a very high cold agglutinin titer of approximately 1:3,000 is necessary for this reaction.[5]

It has been noted that only a few patients with paroxysmal cold hemoglobinuria have clinical manifestations of syphilis. Of the 40 patients reported since 1932, only 1 had a manifest lesion (interstitial keratitis) at the same time as the hemoglobinuria. Following inadequate antisyphilitic therapy, several patients have shown improvement in their symptoms of hemoglobinuria but have later exhibited signs of neurosyphilis.[6]

Routine antisyphilitic treatment of patients with paroxysmal cold hemoglobinuria is usually efficacious in producing a clinical cure or in ameliorating the severity of the reaction. Only 2 cases have been reported treated with penicillin. One patient had a decrease in symptoms and a persistently positive Rosenbach test two months following treatment with 3.6 million units of penicillin.[7] The other patient had a clinical cure after receiving 5 million units of penicillin but continued to have moderate reactions to the cold water test six months after treatment.[2a]

Penicillin has also been administered to a patient with Raynaud's syndrome and syphilis who had a positive Donath-Landsteiner test but did not exhibit hemoglobinuria.[8] There was no clinical improvement two months after treatment.

Our patient has shown complete clinical recovery following administration of 4.8 million units of penicillin.

SUMMARY

A patient with early dementia paralytica associated with paroxysmal cold hemoglobinuria is reported. Treatment with penicillin has produced good clinical results.

MASS PENICILLIN PROPHYLAXIS

An Experiment with Negative Results

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and
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The great incidence of respiratory disease and the resultant loss of time from work or regular activities have led many investigators to seek a means to prevent this type of morbidity. We were first struck by the favorable reports of the prophylactic use of the sulfonamide drugs in both the army and the navy during

5. Stats, D.: Cold Hemagglutination and Cold Hemolysis: Hemolysis Produced by Shaking Cold Agglutinated Erythrocytes, J. Clin. Investigation **24**: 33 (Jan.) 1945.

6. Cited by Becker.[2a]

7. Goldberg, L. C.: Treatment of Paroxysmal Cold Hemoglobinuria with Penicillin, Am. J. Syph., Gonor. & Ven. Dis. **31**: 361 (March) 1947.

8. Davis, J. P., and Rosenbaum, D.: Cold Autohemolysis Associated with Raynaud's Syndrome, Ann. Int. Med. **30**: 681-691 (March) 1949.

From the Departments of Public Health and Medicine, Permanente Hospitals.

The penicillin used in this study was supplied by Lederle Laboratories Division of American Cyanamid Company.

Abraham Gans, Ph.B., helped to code and tabulate data on International Business Machine cards; Martha Eaton, A.B., Sc.M., assisted in the interpretation of statistical data.

the war,[1] even though later articles rather coolly emphasized the development of sulfonamide resistance by bacterial organisms.[2]

Through serving medically the members of a voluntary health insurance plan, we would have had the opportunity to try these drugs on a large civilian population and would have yielded to the temptation to do so, were it not for the reports of toxicity,[1a] and even of agranulocytosis and death,[1b] despite the administration of small daily doses. With the advent of penicillin there came the universal recognition of its relative harmlessness, and accordingly an important barrier was removed from initiation of a large scale prophylactic experiment on a civilian population.

Reports of the preventive value of penicillin, notably against rheumatic fever in children, have been favorable, though the groups of subjects were small. Lapin [3] reported on the oral administration of 50,000 units of penicillin twice a day to children aged 8 months to 10 years. He noted a 75 per cent decrease in febrile days in the group of 148 children receiving penicillin compared to their experience in the preceding year, and a 70 per cent decrease in febrile days compared to the results among 110 other children who served as controls. The control group received nothing, not even a placebo.

Maliner and Amsterdam [4] reported no recrudescences of rheumatic fever among 22 children with a rheumatic history on administration of penicillin troches three times a day during those months when upper respiratory infections were most prevalent, whereas there were 4 definite recurrences of rheumatic fever in the same number of controls. Burke [6] observed favorable results from penicillin prophylaxis in a study that included both children and adults.

As with the sulfonamide compounds, the question of bacterial resistance to penicillin has been raised. The subject has been discussed by Lapin [3] as well as Milzer and others.[7] Milzer believed that such resistance could be overcome by increasing the size of the prophylactic dose. Lapin found no evidence that resistance developed. Florey [8] has said, "Fortunately it appears to be much more difficult to acquire resistance to penicillin in vivo than in vitro . . ." It was hoped to investigate this aspect of the subject.

METHOD OF STUDY

It was proposed to place a minimum of 1,000 persons on a regimen of orally administered penicillin and another control group of 1,000 on a placebo, daily for a period of a year. The intended dose of a 50,000 unit tablet of penicillin twice a day throughout that period of time for 1,000 persons implied the use of 730,000 tablets and an equal number of placebos. At prevailing minimum rates the penicillin alone would cost over $100,000. Nevertheless, the proposal was presented to Dr. Benjamin Carey of the Lederle Laboratory Division of the American Cyanamid Company, who promptly responded favorably.

Accordingly, a letter asking for volunteers was sent in August, September and October, 1947, to over fifteen thousand heads of families and individual subscribers representing upward of sixty thousand members of the Permanente Health Plan. The letter emphasized the importance of the proposed research and stated frankly that some who accepted the invitation would receive penicillin and others would receive something else "for comparative purposes." The study was limited to family members above 7 years of age.

The letter explained that a month's supply, or sixty tablets, would be given at one time and that those participating in the study would be expected to report to the hospital pharmacy once a month for a new supply. In addition, the participants would be asked to fill out a form at the start of the study and each month thereafter, answering a number of questions about their health. To increase the validity of reports the forms were printed questionnaires containing squares either to be checked for yes or no replies or to have numerical answers inserted. All information thus obtained was to be coded and punched on statistical cards. The research was to be essentially a large scale statistical study.

No attempt was to be made to distinguish between virus and bacterial infections. While the penicillin was not expected to prevent virus infections or the common cold, it seemed that the drug might prevent bacterial complications or sequelae. The letter to subscribers covered this point.

Exactly 2,937 persons accepted the invitation, and all were started on the study; 1,486 in the experimental group and 1,451 controls. Although the response was larger than anticipated, it was expected that a number would drop out, how many no one could predict. As a matter of fact, when the last tablets were dispensed on July 26, 1948, eleven months after the first tablets left the pharmacy window, there were only 631 persons still actively participating in the study; 295 in the experimental group and 336 controls. The falling off of subjects became fairly gradual and uniform until the last few months, when a more rapid decline set in. As the study progressed the smaller number of participants enabled us to increase the size of the dose of penicillin without necessitating the acquisition of more material.

The study produced 9,264 monthly reports. In other words, the records represented 9,264 patient months. The dispensing of penicillin versus placebo was determined at random; those health plan members whose record file number was an odd number received penicillin; those with an even number, the placebo. However, all the members of a family received the same tablets as the head of the family. This resulted in almost perfect penicillin-placebo distribution, 4,582 being in the experimental group and 4,682 being controls.

For best utilization of the penicillin, the subject was requested to take the first dose one-half hour before breakfast and the second dose one-half hour before the evening meal.[5] These and other instructions were carefully printed on the bottle label.

1. (*a*) Watson, R. F.; Schwentker, F. F.; Fetherston, J. E., and Rothbard, S.: Sulfadiazine Prophylaxis in an Epidemic of Scarlet Fever, J. A. M. A. **122**: 730-733 (July 10) 1943. Holbrook, W. P.: The Army Air Forces Rheumatic Fever Control Program, ibid. **126**: 84-87 (Sept. 9) 1944. (*b*) Coburn, A. F.: Prevention of Respirator Tract Bacterial Infections by Sulfadiazine Prophylaxis in United States Navy, ibid. **126**: 88-92 (Sept. 9) 1944. The Prevention of Respiratory Tract Bacterial Infections by Sulfadiazine Prophylaxis in the United States Navy, NAVMED 284, Bureau of Medicine and Surgery, United States Navy Department, Washington, D. C., 1944.

2. Sulfadiazine Resistant Strains of Beta Hemolytic Streptococci, Epidemiology Unit Number 22, J. A. M. A. **129**: 921-926 (Dec. 1) 1945. Damrosch, D. S.: Chemoprophylaxis and Sulfonamide Resistant Streptococci, ibid. **130**: 124-128 (Jan. 19) 1946.

3. Lapin, J. H.: Prophylaxis of Upper Respiratory Infections in Children Treated with Oral Penicillin, J. Pediat. **32**: 119-124 (Feb.) 1948.

4. Maliner, M. M., and Amsterdam, S. D.: Oral Penicillin in the Prophylaxis of Recurrent Rheumatic Fever, J. Pediat. **31**: 658 (Dec.) 1947.

5. Footnote deleted on proof.

6. Burke, P. J.: Penicillin Prophylaxis in Acute Rheumatism, Lancet **1**: 255-256 (Feb. 15) 1947.

7. Milzer, A.; Kohn, K., and MacLean, H.: Oral Prophylaxis of Rheumatic Fever with Penicillin; Resistant Hemolytic Streptocci, J. A. M. A. **136**: 536-538 (Feb. 21) 1948.

8. Florey, H.: New Antibiotic Agents, J. A. M. A. **135**: 1047-1049 (Dec. 20) 1947.

The original form filled out by the volunteer requested such pertinent information as sex, age, race, occupation, previous history in respect to respiratory disease, experience in the past year in regard to number of respiratory infections or time lost from daily routine and past use of tobacco, vitamins, medicine and penicillin.

The monthly report form, which was completed when the month's supply of tablets was replenished, ascertained the subject's respiratory experience in the preceding month in respect to the incidence of infection in himself or members of his family, time lost from work or from regular activities, necessity of visiting a physician and number of days spent in a hospital, if any. Although we were primarily interested in respiratory disease, we also included a number of inquiries on nonrespiratory illness, which followed the general tenor of the foregoing questions.

One inquiry on the monthly report asked the number of tablets which the subject had neglected to take because of memory failure, inconvenience or other reason. If this number were large in the experimental group it might explain a negative result. However, the data thus obtained revealed that not over 4.4 per cent of the penicillin tablets were missed during the course of the study. It is unlikely that this small amount would have affected the outcome of the experiment.

RESULTS

The major results of the study were essentially negative in respect to both respiratory and nonrespiratory illness. In fact, it is striking how similar are the statistics for the penicillin and placebo groups. This has seemed so evident that as far as many of the data are concerned elaborate statistical analysis hardly appeared indicated. Yet, despite the negative results, the work revealed a number of interesting sidelights.

The first trial run of the punch cards was made after the study was in effect approximately four months. Since it was noted that there was no appreciable difference between experimental and control groups, it was decided to double the dose; each volunteer was therefore asked to take two of the 50,000 unit tablets twice a day. After the double dose had been maintained for three months the results again proved to be negative. The dose was then quadrupled, giving each subject 400,000 units of penicillin daily. Again after four months the results were still negative. The number of patient months on single, double and quadrupled doses was fairly well distributed; namely, 3,582, 3,685 and 1,997 (or 38.7 per cent, 39.8 per cent and 21.5 per cent of the total), respectively. The results are shown in table 1.

The data in this table will be reviewed briefly. In a comparison of experimental and control groups, actual figures would have little meaning unless related to the number of persons in each group. This relationship is expressed as a ratio and calculated in percentage. In the table the percentages which favor, however slightly, the users of penicillin are in bold face type, as are the corresponding figures from which the percentages are derived.

In the left half of the table there is an isolated instance of a statistically significant difference favoring the experimental group. This occurs in respect to the time lost from work or activity due to respiratory illness when the subjects were on the double dose. The number of days lost and corresponding percentages are 969, or 53.6 per cent, for the penicillin group and 1,184, or 63.2 per cent, for the control group. However, the preceding columns reveal that the number of persons involved was 229 for the penicillin group and 243 for the placebo group; the respective percentages being 12.7 and 12.9, or essentially the same figure. So the difference in days lost cannot be explained on the basis of the number of persons. As a matter of fact, it can be shown that the difference in lost time was actually due to more serious and protracted illness among a few persons in the control group, a possibly fortuitous circumstance.

To the right of the table the users of penicillin on single and quadruple doses are favored in respect to the number of days lost from work or activity and in respect to the number of days hospitalized (nonrespiratory cause), but those on double dose are not so favored. Since there is no logical reason why single and quadruple doses should have an effect which could not be obtained by a double or intermediate dose, the results must be considered fortuitous.

Repeated analyses have been made of the statistical cards, separating out those who reported for the preceding twelve months a varying incidence of respiratory infection or varying days of time lost from respiratory cause. Again results were negative. The statistical cards have been studied in respect to use of tobacco, to mention another breakdown, and nothing significant was found.

TABLE 1.—*Data Concerning Respiratory and Nonrespiratory Illness for Penicillin and Control Groups on Single Double and Quadruple Doses*

			Respiratory Cause												Nonrespiratory Cause							
					Time Lost from Work or Activity				Hospitalization								Time Lost from Work or Activity				Hospitalization			
		Total No. of Persons Reporting	Persons Reporting Infections		Persons		Days		Persons		Days		Persons Reporting Family Respiratory Infections		Persons Reporting Illness		Persons		Days		Persons		Days	
Dosage	Group		No.	%*	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Single	Penicillin.....	1,779	652	36.6	**184**	**10.9**	**642**	**36.1**	89	5.0	14	0.8	43	2.4	748	42.0	224	12.6	103	5.8	**350**	**20.2**	**10**	**0.6**	**57**	**3.2**
(Sept. to Dec.)	Control.....	1,808	643	35.7	**203**	**11.3**	**681**	**37.7**	78	4.3	6	0.3	19	1.1	731	40.5	156	8.7	97	5.4	**498**	**27.7**	**15**	**0.8**	**78**	**4.3**
Double	Penicillin.....	1,808	633	35.0	**229**	**12.7**	**969**	**53.6**	104	5.8	**4**	**0.2**	**9**	**0.5**	824	45.6	186	10.3	98	5.4	718	39.7	29	1.6	192	10.6
(Jan. to March)	Control.....	1,877	622	33.2	**243**	**12.9**	**1,184**	**63.2**	108	5.8	**8**	**0.4**	**25**	**1.3**	754	40.1	157	8.4	74	3.9	335	17.9	16	0.9	145	7.7
Quadruple	Penicillin.....	995	230	23.1	67	6.7	**234**	**23.5**	38	3.8	..	...	..	...	312	31.4	69	6.9	32	3.2	**191**	**19.2**	**10**	**1.0**	**55**	**5.5**
(April to July)	Control.....	1,002	201	20.1	64	6.4	**255**	**25.5**	38	3.8	1	0.1	1	0.1	246	24.6	59	5.9	31	3.1	**410**	**41.0**	**11**	**1.1**	**66**	**6.6**

* The percentage expresses the ratio that the preceding figure bears to the total number of reporting subjects in the corresponding group (column at extreme left). Percentages favoring the penicillin group are in bold face type; percentages favoring the control group, in light face. The percentage figure and the figure preceding it are set in the same type.

In view of previous reports of successful prophylaxis in children, the records were studied by sex and age in decades. The observations are reported in table 2. Only a few scattered figures favoring the penicillin group are statistically significant, but there is no consistent, statistically significant advantage for the penicillin users of either sex in any age group.

TOXICITY

We were impressed by the relatively large number of mildly or moderately severe toxic reactions to oral penicillin. There were no disastrous effects, however. Only 1 patient required brief hospitalization for a dermatitis.

The large number of reactions is in contrast to the experience of Lapin, who reported mild toxicity in only 3 of 148 children. According to most writers, the percentage of toxic reactions to oral penicillin is small and the reactions are mild. In this study the single dose screened out almost all the sensitive subjects, so that doubling or quadrupling the dose produced practically no additional toxic reactions other than mild digestive upset in which the quantity of tablets probably played a part. But the strange thing is that those receiving the placebo, a tablet of calcium carbonate of equal size, reported almost as much discomfort as did those receiving the penicillin.

Of course, in a study of this sort where subjects could drop out at will, there was no way of knowing the exact percentage of toxic reactions. In order to approximate the figure, self-addressed, prepaid postcards were sent to 1,500 of those who discontinued (750 on penicillin and an equal number on placebos). From these, 627 replies were received; 322 from experimental subjects and 305 from controls. The replies are analyzed in table 3.

It will be noted that 90 of those who received penicillin reported that "the tablets did not agree with them," most of the subjects indicating digestive or cutaneous disorders, or headaches. Sixty-four persons who received the calcium carbonate placebo signified similar subjective or objective complaints.

As to the percentage of reactions among the experimental subjects, it can be said that there was considerably upward of 6.1 per cent (90 of 1,486 persons receiving penicillin). The postcards reached only about

TABLE 2.—*Data Concerning Respiratory Illness for Penicillin and Control Groups According to Age and Sex*

Ages	Males: Group	Total Number of Persons Reporting	Persons Reporting Infections		Days Lost from Work or Activity		Persons Who Consulted Physician		Days Hospitalized		Persons Reporting Family Respiratory Infections	
			No.	%*	No.	%	No.	%	No.	%	No.	%
7 to 9	Penicillin	141	**36**	**25.6**	**93**	**66.0**	**10**	**7.1**	1	0.7	71	50.4
	Control	90	**32**	**35.6**	**118**	**131.0**	**12**	**13.3**	..	...	43	47.8
10 to 19	Penicillin	187	75	40.1	173	92.5	17	9.1	..	...	**90**	**48.1**
	Control	198	65	32.8	90	45.4	4	2.0	1	0.5	**98**	**49.5**
20 to 29	Penicillin	247	**90**	**36.4**	**50**	**20.3**	7	**2.8**	..	...	112	45.4
	Control	269	**106**	**39.4**	**89**	**33.1**	10	**3.7**	..	...	118	43.8
30 to 39	Penicillin	606	**221**	**36.4**	**206**	**34.0**	27	4.5	..	...	**292**	**48.2**
	Control	552	**210**	**38.0**	**207**	**37.5**	23	4.2	4	0.7	**270**	**48.9**
40 to 49	Penicillin	463	156	33.7	159	34.4	14	**3.0**	10	2.2	193	41.7
	Control	632	191	30.2	195	30.9	**37**	**5.9**	3	0.5	215	34.0
50 to 59	Penicillin	531	145	27.3	**144**	**27.1**	30	5.7	28	5.3	124	23.4
	Control	567	134	23.6	**199**	**35.1**	25	4.4	26	4.6	119	21.0
60 to 69	Penicillin	248	60	24.2	**49**	**19.8**	11	**4.4**	..	...	52	21.0
	Control	288	69	23.9	**245**	**85.0**	18	**6.2**	10	3.5	45	15.6
All others †	Penicillin	67	**16**	**23.9**	6	9.0	**2**	**3.0**	..	...	15	22.4
	Control	57	15	**26.4**	5	8.8	**3**	**5.3**	..	...	7	12.3
	Females: Group											
7 to 9	Penicillin	117	47	40.1	137	117.0	7	6.0	5	4.3	65	55.6
	Control	62	19	30.6	34	54.8	2	3.2	..	...	28	45.2
10 to 19	Penicillin	192	75	39.0	72	**37.5**	**6**	**3.1**	..	...	131	68.2
	Control	176	66	37.5	**113**	**64.2**	**6**	**3.4**	..	...	82	46.6
20 to 29	Penicillin	388	**135**	**34.8**	**127**	**32.7**	**15**	**3.9**	5	1.3	195	50.2
	Control	375	**134**	**35.7**	**165**	**44.2**	**21**	**5.6**	..	...	170	45.3
30 to 39	Penicillin	506	**188**	**37.1**	**234**	**46.2**	31	6.1	3	0.6	**239**	**47.2**
	Control	526	**197**	**37.4**	**280**	**53.2**	23	4.4	1	0.2	**250**	**47.5**
40 to 49	Penicillin	434	130	30.0	**210**	**48.4**	22	5.1	..	...	**161**	**37.1**
	Control	437	117	26.8	**216**	**49.4**	19	4.4	..	...	**182**	**41.6**
50 to 59	Penicillin	344	106	30.8	160	46.5	28	8.1	..	...	118	34.3
	Control	293	70	23.9	127	43.4	16	5.5	..	...	61	20.8
60 to 69	Penicillin	89	31	34.8	17	19.1	**2**	**2.2**	..	...	**22**	**24.8**
	Control	144	34	23.6	**28**	**19.4**	**4**	**2.8**	..	...	**37**	**25.7**
All others †	Penicillin	22	**4**	**18.2**	**8**	**36.4**	2	9.1	..	...	**4**	**18.2**
	Control	16	7	**43.7**	**8**	**50.0**	1	6.3	..	...	**6**	**37.5**

* The percentage expresses the ratio that the preceding figure bears to the total number of reporting subjects in the corresponding group (column at extreme left). Percentages favoring the penicillin group are in bold face type; percentages favoring the control group, in light face. The percentage figure and the figure preceding it are set in the same type.
† Including nonidentified.

five-eighths of the penicillin-taking subjects who dropped out; assuming that there was the same proportion of reactions in those who were not polled, the figure would be increased to 9.7 per cent, yet this figure takes no account of additional persons with untoward reactions who did not reply to the postal inquiry.

There were reasons other than unpleasant reactions which caused persons to drop out, such as the inconvenience of getting to the hospital (142 on penicillin, 123 on placebo). Sixty on penicillin and 83 on the placebo said they ceased to cooperate in the study because they experienced no benefit. Only 6 on the placebo admitted frankly that they discontinued because they suspected that they were getting the placebo.

TABLE 3.—*Reasons for Dropping Out of Study*

Analysis of Replies from 322 Experimental Subjects and 305 Controls	Number Reporting		
Type of Reaction	Penicillin Group	Control Group	Total
Indigestion	40	29	69
Skin	27	10	37
Headache	18	8	26
Sneezing, stuffy nose	1	4	5
Backache	0	2	2
Dizziness	0	2	2
Malaise	0	2	2
Loss in weight	0	2	2
Faster breathing	0	2	2
Rectal trouble, piles	0	2	2
Pain in Chest	1	0	1
Cough	0	1	1
Pain in heart	1	0	1
Nervousness	1	0	1
Weakness	1	0	1
Total	90	64	154
Other Reasons for Dropping Out			
Inconvenience	142	123	265
Received no help	60	83	143
Not stated	35	52	87
Medical or surgical disability	10	8	18
Might acquire resistance	8	4	12
Discontinued membership in Health Plan	3	9	12
Pregnancy	6	3	9
Doctor's request	2	6	8
Misunderstood routine	4	3	7
Suspected tablets were placebos	0	6	6
Couldn't swallow tablets	4	1	5
Miscellaneous	2	1	3
Total	276	299	575

Eight discontinued the penicillin and 4 the placebo because they had read that they might acquire resistance to penicillin. Other reasons included pregnancy and difficulty in swallowing the tablets. One man quit because he was gaining weight, the calcium carbonate of the placebo evidently helping his peptic ulcer.

COMMENTS

While many mildly disagreeable reactions to the tablets were thus recorded, it is interesting to note that many glowing reports of subjective benefits were reported, despite the negative results of the study. And there were almost as many enthusiasts in the control group as in the experimental group. This seems to substantiate the well known fact that persons may at times react favorably to a situation in which they are merely shown attention; for example, the kind of special attention that made them a part of a seemingly important mass penicillin experiment.

Subjects still come to the hospital requesting an opportunity to purchase penicillin for prophylactic use, but the effort is made to discourage them on the basis of actual results of the study and the cost of the antibiotic. Likewise, some of these demands for continued medication come from those who received the placebo. Thus, this study emphasizes the value of having a large number of subjects on a controlled program before arriving at favorable conclusions, and this is particularly true where reliance would have to be made on subjective improvement alone.

While it was not the intention of the study to make chemical or bacterial analyses, blood levels of penicillin were taken in 6 subjects who ingested two tablets about a half hour before breakfast. These levels, taken an hour after the meal, varied from 0.15 to 0.31 units, which are considered to be effective doses.[3]

It would have been interesting to determine whether the taking of penicillin tablets possibly prevented a gonococcic infection. No one taking either penicillin tablets or placebos reported to the hospital or clinic with such an infection. A patient on penicillin was hospitalized with a tubo-ovarian abscess, but the organism was Escherichia coli. This fact is interesting because, as far as is known, the organism is not affected by penicillin. In this case smears and cultures revealed no gonococci. During the course of the study 22 cases of gonorrhea were observed among health plan members not on the study, but obviously no conclusion can be drawn from this limited observation.

Finally, because of the references in the literature to acquired resistance to penicillin, already commented on, a review was made of the hospital records of all persons on the study who required hospitalization at the Permanente Hospitals and who received therapeutic doses of penicillin for their primary illness or for associated infection such as a complicating pneumonia. There were 8 patients in this group. Two of them, 1 with bronchogenic carcinoma and the other with phosphorus poisoning, died from the primary illness. Of the remaining 6 patients, 2 subjects had been on the study eight months (1 had asthmatic bronchitis and the other, the tubo-ovarian abscess previously mentioned); 1 subject had taken the penicillin tablets for seven months (another case of asthmatic bronchitis); 1 for six months (a case of secondarily infected second and third degree burns); 1 for five months (an incomplete abortion) and 1 for one month (a nonspecific prostatitis). Except for the E. coli in the case of tubo-ovarian abscess, the infecting organism was not identified. In no case, however, was there any evidence that the penicillin was less effective because of its previous prophylactic administration.

SUMMARY

In conclusion, this study of mass penicillin prophylaxis, which involved 4,582 patient months in the experimental group and 4,682 patient months in the control group, discloses practically no difference for respiratory and nonrespiratory illness in respect to incidence of sickness, days lost from work or regular activities, days of hospitalization or number of persons who sought medical consultations. Respiratory infection in other members of the family was not affected.

There were many relatively mild reactions both to penicillin and to the placebo, besides many reports of subjective improvement experienced by both experimental and control subjects despite the negative results.

There was no evidence that subsequent therapeutic administration of penicillin was hampered by the previous taking of prophylactic doses.

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VALIDITY OF PNEUMOENCEPHALOGRAPHIC DIAGNOSIS

A Study of Five Hundred Pneumoencephalograms in Children

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When Dandy [1] thirty years ago introduced the procedure of pneumoencephalography he offered neurologists a simple nonoperative method of visualizing certain of the structures of the brain during life. Gradually enthusiasm increased for the new method. Pancoast and Fay [2] believed that encephalography is indicated in any condition of the brain which might impair the cerebrospinal pathways. Davidoff and Dyke [3] stated: "Excluding individuals with increased intracranial pressure we believe that all patients with organic disease of the brain upon whom a diagnosis cannot definitely be made, whether it be with regard to the nature or location of the disease, should be subjected to encephalography." Pendergrass [4] expressed a similar opinion.

Just as slowly the enthusiasm waned, and neurologists began to doubt that the procedure was necessary in most cases. Thus Adson [5] questioned the value of frequent and promiscuous use of pneumoencephalography and doubted whether sufficient additional information was obtained in many cases to compensate the patient for the suffering he must endure.

In searching for an answer to the question we have reviewed 500 pneumoencephalographs of patients on our service and offer the following material.

THE MATERIAL

The Epilepsies.—There were approximately 250 encephalographic studies performed on children with the clinical diagnosis of the convulsive state. In 55 per cent of these cases the encephalogram was interpreted as pathologic by the roentgenologist. However, in the great majority of these cases (49 per cent) the pathologic entity reported was bilateral or unilateral "cerebral atrophy or hypoplasia." (This diagnosis will be discussed later.) In only 6 per cent of the convulsive cases (in which suspicion of no other clinical entity such as neoplasm was seriously entertained) were more specific pathologic conditions found, such as porencephaly, agenesis of the corpus callosum, tuberous sclerosis, neoplasm, and internal hydrocephaly secondary to subdural hematoma.

In 8 per cent of the jacksonian type of convulsions pathologic lesions were reported on the encephalogram —and these pathologic entities were all "cerebral hypoplasia."

The clinical diagnosis and the treatment was unchanged by the encephalographic observations in 88 per cent of the patients with epilepsy. In 6 per cent of these persons with convulsive states, in whom the possibility of a brain tumor or subdural hematoma was entertained, the diagnosis was clarified by the elimination of these possibilities. In another 6 per cent the diagnoses were changed from the convulsive state to some of the diagnoses previously listed.

Brain Tumors.—A ventriculogram rather than an encephalogram was made in the majority of children who were suspected of cerebral tumor. Therefore the analysis of the following 29 cases does not represent the total material on the child neurology wards.

In 10 cases a tumor was visualized in the encephalogram in the area predetermined clinically. In 3 cases the localization of the tumor was changed from intraventricular neoplasm to craniopharyngioma, from intracranial neoplasm to optic chiasma glioma, from left frontal neoplasm to right frontal neoplasm.

The diagnoses were clarified and changed in 11 brain tumor suspects from internal hydrocephalus to craniopharyngioma in 1 case and to intraventricular cyst in another, from cerebellar neoplasm to cerebellar sclerosis, from subdural hematoma to idiopathic grand mal and cerebral hypoplasia and from brain tumor suspect to post-traumatic encephalopathy.

In 4 cases the encephalogram was misleading. It did not reveal a papilloma of the choroid plexus of the fourth ventricle in 1 case or papilloma of the choroid plexus of the left lateral ventricle in another case. These were discovered at operation in the former instance and at autopsy in the latter. In a third case a tumor of the brain stem was not visualized by the encephalogram. In a fourth case the encephalogram disclosed normal conditions in 1935 but, when repeated in 1939, revealed a tumor of the left temporal lobe.

The encephalogram is of great value in those suspected of having tumor of the brain. It usually verifies, localizes or rules out neoplasms. However, in 21 per cent of our cases in which a definite neoplasm existed the encephalogram did not reveal the tumor. A normal encephalogram does not rule out neoplasm.

Post-Traumatic Syndrome.—There were 35 encephalographic studies of children with clinical evidence of post-traumatic syndrome. In 55 per cent of these the encephalogram was interpreted as revealing pathologic conditions. However, "cerebral hypoplasia" was the condition most commonly found. Porencephaly was occasionally noted. On the whole the encephalogram was not revealing, although it did tend to rule out subdural hematoma.

Postinfectious Group.—Encephalograms were made on 40 children with the clinical diagnosis of postinfectious syndrome. Cerebral hypoplasia was reported in 50 per cent of the encephalograms, and other conditions such as toxoplasmic encephalitis, porencephaly and aplasia of the corpus callosum were reported in another 10 per cent of the cases. The encephalogram was not particularly helpful as a diagnostic aid in the postinfectious group.

Congenital Anomalies and Miscellaneous Lesions.—There were approximately 150 cases of congenital anomalies and miscellaneous lesions. In 65 per cent of these cases pathologic findings were reported by the roentgenologist. Although about 59 per cent of the cases displayed only cerebral hypoplasia, many interesting lesions were uncovered by the encephalogram in the other 6 per cent. The clinical diagnosis of hydrocephalus was changed in 1 case to agenesis of the corpus callosum and in a second to cerebral atrophy. Pro-

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nounced examples of cerebral and cerebellar atrophy, microcephaly, hydrocephalus and various structural anomalies were visualized.

Mental Deficiency.—The material was analyzed to determine the correlation between the pneumoencephalographic diagnosis (particularly cerebral hypoplasia or atrophy) and the intelligence quotient. There were 33 patients with a pneumoencephalographic diagnosis of cerebral hypoplasia whose intelligence quotient varied from 20 to 149. Ten of these patients had an intelligence quotient over 80 and only 12 had an intelligence quotient below 50.

Table 1 shows the degree of correlation between the intelligence quotient and the pneumoencephalographic diagnosis of cerebral hypoplasia or atrophy.

It is interesting to note that in 22 of 34 severely defective children (intelligence quotient below 50), the encephalogram showed no evidence of cerebral hypoplasia or atrophy. However, hypoplasia was discovered more frequently in the severely defective children than in those with normal intelligence.

TABLE 1.—*Pneumoencephalographic Diagnosis*

I. Q.	No. of Patients	Normal	Atrophy or Hypoplasia
Above 95	89	83	6
90 to 95	20	18	2
80 to 90	22	20	2
70 to 80	26	18	8
50 to 70	30	27	3
25 to 50	28	18	10
Below 25	6	4	2

TABLE 2.—*Information Obtained from Encephalograms*

Clinical Diagnosis	Number of Cases	Normal %	Abnormal,* %	Abnormal Other Than Cerebral Hypoplasia or Asymmetric Ventricles, % of Total
Convulsive state	250	..	..	..
Generalized	...	45	55	..
Jacksonian	...	92	8	None
Brain tumors	29	33	67	52
Post-traumatic syndrome	35	45	55	5
Postinfectious states	40	40	60	10
Congenital anomalies, Mental Retardation, Miscellaneous	150	35	65	6

* The abnormal includes reports of cerebral hypoplasia.

The diagnosis of cerebral hypoplasia by the roentgenologist does not mean an impaired intelligence; nor does a completely normal encephalogram mean normal intelligence.

COMMENT

Pneumoencephalography is a method of neurosurgical not neurologic diagnosis. If any therapeutic indications are revealed by it they are of necessity neurosurgical. Pneumoencephalography shows only (1) size, shape and position of ventricles; (2) size and shape of the basal cisterns, and (3) in some cases the pattern of the cerebral convolutions and sulci. The primary and enforcing indications are (*a*) signs of increased intracranial pressure without localizing signs—although in many of these cases ventriculography is the method of choice—and (*b*) increasing focal cerebral signs in the absence of increased intracranial pressure. In the epilepsies we believe that at least two of the following conditions should be present to justify pneumoencephalography: first, that the convulsions are always or predominantly one-sided and occur always on the same side; second, that there are positive neurologic signs on the side of the convulsions; third, that the electroencephalogram discloses abnormal signs only or predominantly on the side opposite the convulsions and the physical signs, and fourth, that the convulsions and other signs are increasing in frequency or severity, or both. Casamajor and others [6] compared the results of the foregoing three methods of clinical investigation in focal convulsive seizures in children and found that the clinical and electroencephalographic data bore closer relationship to each other and to the locality of the convulsions than did those from pneumoencephalography. The latter gave little help either for diagnosis or treatment in most cases.

We have cast doubt on the validity of the diagnosis of cerebral atrophy or hypoplasia from pneumoencephalographic films. Davidoff and Dyke [7] in their book "The Normal Encephalogram" admit that in all the cases which they reported there was ample evidence that suspicion as to the normality of the brains was justified. However, they checked their results with postmortem examinations, standard textbooks of anatomy and the study of 4,000 pneumoencephalograms. All this in their opinion gave them "a fairly accurate idea of the normal appearance of the structures." Their criteria of cerebral atrophy or hypoplasia were not any too definite. They judged atrophy or hypoplasia from the widening of the cerebral sulci and enlargement of the ventricles, although they gave no accurate measurements. Later these authors [7] supplied some more accurate figures as to the size of the ventricles, giving what they consider the normal limits of size. Apparently these measurements were taken on adult brains. Hence, it would be difficult to postulate the normal in children of different ages.

The pneumoencephalographic observations in mental deficiency are of especial interest. The data seem to prove conclusively that there is no correlation between the structure of the brain and intelligence in the vast majority of cases. There would appear to be no reason for pneumoencephalography in persons who are mentally defective unless there is definite evidence of a focal cerebral lesion. It is of little practical importance to know what sort of a brain, as shown by pneumoencephalography, a mentally defective person has; that is the brain with which he must go through life, and gas studies will not alter the prognosis or treatment in the slightest.

CONCLUSIONS

1. Pneumoencephalography is a method of neurosurgical not neurologic diagnosis.

2. Pneumoencephalography is a necessary diagnostic technic when tumors of the brain are suspected.

3. Pneumoencephalography has little to offer in clarifying the diagnosis or indicating the treatment in most cases of epilepsy or the convulsive state.

4. There is no indication for pneumoencephalography in persons who are mentally defective unless there are also signs of growing focal lesions of the brain.

6. Casamajor, L.; Smith, J. R.; Constable, K., and Walter, C. W.: The Electroencephalogram in Children with Focal Convulsive Seizures, Arch. Neurol. & Psychiat. **45**: 834 (May) 1941.

7. Dyke, C. J., and Davidoff, L. M.: The Pneumoencephalographic Appearance of Hemangeoblastoma of the Cerebellum, Am. J. Roentgenol. **44**: 1, 1940.

Clinical Notes, Suggestions and New Instruments

SERUM HEPATITIS IN A BLOOD BANK WORKER

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Numerous clinical and experimental studies within the past six years have demonstrated that virus hepatitis, including both the infectious and the homologous serum type, is transmissible to human beings by the parenteral injection of human serum. Apparently the only clinical differentiating characteristic of these two virus infections, when both are thus transmitted, is the shorter (twenty to forty days) incubation period in the case of the former and the longer (forty to one hundred and sixty days) incubation period in the latter. Neefe [1] has proposed the terminology "virus hepatitis I.H." and "virus hepatitis S.H." to differentiate the naturally occurring disease from the artificially transmitted homologous serum type.

Most commonly reported has been the accidental transmission of virus hepatitis by means of transfusions of whole blood, plasma and convalescent serum and injections of vaccines to which human serum has been added.[2] Less commonly encountered have been accidental transmission by use of unsterile syringes or needles, as in penicillin therapy [3] or in arsenical antisyphilitic therapy [4] or even during ordinary venipuncture for withdrawal of blood; the latter hazard was reported by Mendelssohn and Witts [5]; who noted that blood regurgitates back into a vein when the tourniquet is released. Finally, the use of the "multiple dose per syringe" technic for injections into large groups of persons has been a source for transmission of the virus, even when a sterile needle is used for each injection.[6] The probable mode for contaminating the material in the syringe, in this instance, is the aspiration of tiny amounts of infective serum (from the infected patient source) while testing to determine that the needle is not in a vein. Havens [7] has shown that parenteral inoculation of as little as 0.01 cc. of acute phase serum from a patient with infectious hepatitis is sufficient to cause the disease in a human volunteer.

In all these accidental transmissions of virus hepatitis the danger has been to the patient; i. e., to the recipient of the injection. The case herein presented is noteworthy because it strongly suggests a similar danger to the technician who performs the venipuncture or the injection.

REPORT OF A CASE

History.—M. L., a 41 year old woman, was admitted to Beth Israel Hospital on Sept. 23, 1948, with jaundice of twenty-four hours' duration. She was a nurse who for the previous ten months had been employed in the blood bank of a large hospital in New York City. In her duties at the blood bank, she withdrew the needle from the donor's arm and the receiving bottle after the phlebotomy was completed. On many occasions she had pricked her hands and fingers with the needles. Four weeks before admission to the hospital she noticed a lack of energy and fatigue on arising in the morning. For three weeks she noticed the presence of a headache. Anorexia had been present for two weeks. She was a light cigaret smoker, using about 4 packages weekly; about two weeks before admission, she experienced an abrupt distaste for smoking. At that time her stools became clay colored and her urine dark red. Her urinary output diminished, as judged by decreased volume as well as decreased frequency. During these two weeks before her admission pain developed in the epigastrium, with eructations and nausea, and she vomited on one occasion. In the week prior to admission the upper part of her abdomen felt distended, as though her "skirt were too tight," and she lost 4 to 6 pounds (2 to 3 Kg.) in weight. She had no chills, but had a fever during this week, her temperature reaching 102 F. forty-eight hours before admission. On the day before admission she consulted a physician, who observed jaundice and an enlarged liver. Examination of the chemical content of the blood, performed the day prior to admission, revealed: normal total proteins, serum bilirubin 1.8 mg. per hundred cubic centimeters, cephalin flocculation 4 plus at 24 hours, thymol turbidity 23 units, alkaline phosphatase 6.6 units and prothrombin time 19 seconds (control, 14 seconds).

Her past history was noncontributory. She had never been previously jaundiced. She had had no blood or plasma transfusions. She had one child, aged 12. Nobody in the immediate family had been ill in recent months.

Physical Examination.—On admission her temperature was 98.6 F., pulse rate 80 per minute and respirations 20 per minute. Her blood pressure was 128 systolic and 82 diastolic. Her scleras were icteric. Her fauces was injected. There were no enlarged or tender lymph nodes. The heart and lungs were normal. The liver was enlarged 3 fingerbreadths below the costal margin, extending to the level of the umbilicus. It was smooth and tender to fist percussion, the tenderness being elicited immediately on contact with the fist. The spleen was not palpated. There was right costovertebral tenderness but no shoulder tenderness on palpation.

Laboratory Data.—Results of all pertinent blood cell counts, urine analyses and examinations of the chemical content of the blood are recorded in table 1. Roentgenographic examination of the abdomen on the eighth hospital day showed no evidence of gallstones or other abnormalities.

Diagnosis.—The admission diagnosis was virus hepatitis. Without a known incubation period, and in the absence of human transmission experiments, it was impossible to decide whether the I.H. virus or S.H. virus was involved. However, in view of the history of frequent needle pricking of the hands and fingers during the course of work in a blood bank and failure to elicit any other likely source of infection, it was felt that the virus hepatitis here was serum transmitted.

Course.—The patient was placed on a regimen of complete bed rest. Her diet was high in calories with moderately low amounts of fat, and she received supplementary B complex vitamins by mouth and vitamin K parenterally. Accessory lipotropic amino acids were not administered. Liver extract was not administered.

Her temperature rose to 100 F. on the second hospital day and thereafter remained normal. On the fourth hospital day a tender enlarged right posterior auricular lymph node was noted. Liver tenderness was no longer elicited by the fifth hospital day, and the liver had receded by then to 2 fingerbreadths below the costal margin. The patient noted increased urinary output at the beginning of the second week. Coincident with this, her appetite returned to normal and she had nearer normal general strength and sense of well-being. At the end of the second week, she was no longer jaundiced clinically and her serum bilirubin value fell to 0.83 mg. per hundred cubic centimeters (by method of Malloy and Evelyn, normal values 0.1 to 0.25 mg.) Her liver at this stage, still nontender, was palpable 1½ fingerbreadths below the costal margin. She was allowed out of bed at the end of four weeks and experienced no abdominal pains or other untoward symptoms. Her liver did not enlarge any further or become tender on this out of bed activity. Jaundice did not return. She was discharged on October 25, thirty-three days after admission. At the time of discharge results of the thymol

From the Medical Service, Beth Israel Hospital.

1. Neefe, J. R.: Recent Advances in the Knowledge of "Virus Hepatitis," M. Clin. North America **30**: 1407, 1946.
2. Havens, W. P., Jr.: Infectious Hepatitis, Medicine **27**: 279, 1948.
3. (a) Turner, R.: Hepatitis After Penicillin Injections, Lancet **1**: 108, 1946. (b) Howells, L., and Kerr, J. D. O.: Hepatitis After Penicillin Injections, Lancet **1**: 51, 1946. (c) Hughes, R. R.: Post-Penicillin Jaundice, Brit. M. J. **2**: 685, 1946.
4. Truelove, S. C., and Hogben, L. A.: Documentary Study of Jaundice Associated with Syphilis Treatment and Blood Transfusion, Brit. J. Social Med. **1**: 18, 1947.
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6. Howells and Kerr.[3b] Capps, R. B.; Sborov, V., and Scheifley, C. H.: A Syringe-Transmitted Epidemic of Infectious Hepatitis, J. A. M. A. **136**: 819 (March 20) 1948.
7. Havens, W. P., Jr.: Period of Infectivity of Patients with Experimentally Introduced Infectious Hepatitis, J. Exper. Med. **83**: 251, 1946.

turbidity and cephalin flocculation tests were still abnormal, the result of the former, however, showing a diminution from a maximum of 37 to 13.5 units. The bilirubin was 0.21 mg. per hundred cubic centimeters. Her liver was nontender and palpable about 2 fingerbreadths below the costal margin.

Two months after discharge the patient was clinically well. Her appetite was good, and her taste for cigarets had returned. She tended to tire more readily than prior to her illness. Her liver was not tender, but still extended 2 fingerbreadths below the costal margin. The thymol turbidity was 5.8 units, the result of the cephalin flocculation test was 3 plus at 48 hours and the serum bilirubin 0.52 mg. per hundred cubic centimeters.

punctures, finger puncture or any type of needling of human beings to protect himself against accidental pricking, even when sterile instruments are assuredly employed.

The case introduces a new type of occupational hazard which merits compensation. The New York State Workmen's Compensation Board, after formal hearing of this case on Jan. 21, 1949, decided that it was the result of an accident and that a causal relationship had been established between the illness and the conditions of employment and made an award in favor of the patient. This represents, to our knowledge, the first such instance of the granting of a compensation award for a virus hepatitis infection.

TABLE 1.—*Pertinent Laboratory Data in the Case Reported*

Date, 1948	White Blood Cell Count: Total	White Blood Cell Count: Differential	White Blood Cell Count: Abnormal Lymphocytes	Urine	Thymol Turbidity, Units	Cephalin Flocculation	Alkaline Phosphatase, Units	Serum Proteins, Gm./100 Cc.: Total	Serum Proteins, Gm./100 Cc.: Albumin	Serum Proteins, Gm./100 Cc.: Globulin	Serum Bilirubin, Mg./100 Cc.	Prothrombin Time, Seconds	Results of Sulfobromophthalein Test	Serum Cholesterol, Mg./100 Cc.: Total	Serum Cholesterol, Mg./100 Cc.: Esters
9/22	.....	.....	.....	.....	23.0	24 hr.: 4+	6.6	....	....	....	1.8	19	..	...	...
9/23	6,900	33 polymorphonuclear cells 13 staff cells 6 eosinophils 2 basophils 24 lymphocytes 22 monocytes	Present	1.010 amber Albumin: trace Bile: + Urobilinogen: 1/160	....	.....	...	....	....	....	...	..	..	...	...
9/27	.....	.....	.....	.....	37.7	24 hr.: 4+	4.7	7.32	3.77	3.55	2.5	..	..	256	...
9/28	.....	.....	.....	1.022 Albumin: 2+ Bile: 0 Urobilinogen: 1/80	....	.....	...	....	....	....	...	..	..	...	...
9/29	.....	.....	.....	1.014 Urobilinogen: 1/640	....	.....	...	....	....	....	...	..	..	...	...
10/ 2	6,900	34 polymorphonuclear cells 13 staff cells 2 eosinophils 43 lymphocytes 8 monocytes	Absent	.....	....	.....	...	....	....	....	...	..	..	...	...
10/ 6	.....	.....	.....	.....	22.1	24 hr.: 4+	4.0	7.20	5.05	2.15	0.83	14.8	..	312	245
10/12	.....	.....	.....	.....	14.7	48 hr.: 3+	3.2	7.30	4.53	2.77	0.81	..	12% Retained in 30 min.	285	173
10/19	.....	.....	.....	.....	12.8	24 hr.: 3+ 48 hr.: 3-4+	...	7.80	5.03	2.77	0.52	..	..	273	167
10/25	.....	.....	.....	.....	13.5	24 hr.: 2+ 48 hr.: 4+	3.8	7.70	5.06	2.64	0.21	..	3% Retained in 30 min.	342	238
11/ 4	.....	.....	.....	.....	7.3	24 hr.: 3-4+ 48 hr.: 4+	2.8	6.02	3.93	2.09	0.99	..	..	271	160
11/11	.....	.....	.....	.....	9.2	48 hr.: 4+	4.7	....	....	....	0.12	..	..	278	150
12/21	.....	.....	.....	.....	5.8	24 hr.: 2+ 48 hr.: 3+	...	....	....	....	0.52	..	..	300	213

COMMENT

The history of multiple needle pricks on hand and fingers sustained by this patient in the course of her duties at the blood bank persuades us to conclude that this was the mode of her infection. Admittedly, we cannot be absolutely certain that she had not contracted sporadic infectious hepatitis by other than parenteral means, but we think that this is unlikely in view of the highly suggestive history. However, we make no attempt to define the virus type involved as of the I.H. or S.H. variety, since we are in no position to decide the absolute incubation period and since both the virus types may be transmitted parenterally.[8]

The hazard which this case illustrates has wide applicability. It points to the obvious necessity for caution on the part of a physician or technician who engages in phlebotomies, veni-

8. Neefe.[1] Havens.[2]

This case provided us with the opportunity to study the sheep cell agglutination reactions in virus hepatitis, as part of a larger study stimulated by the clinical and hematologic similarities between virus hepatitis and infectious mononucleosis. The method employed for the test follows that of Davidsohn,[9] with final volumes totaling 0.35 cc., the tubes standing at room temperature for two hours and read immediately thereafter and titers expressed as dilutions prior to the addition of the 2 per cent sheep cell suspension. The results, including absorption studies with boiled guinea pig kidney, boiled ox erythrocytes and human liver, are detailed in table 2. The human liver antigen absorption study was prompted by the recent report by Eaton, Murphy and Hanford[10] of consistent absorptions

9. Davidsohn, I.: Test for Infectious Mononucleosis, Am. J. Clin. Path. (Tech. Supp.) **2**: 56, 1938.

10. Eaton, M. D.; Murphy, W. D., and Hanford, V. L.: Heterogenetic Antibodies in Acute Hepatitis, J. Exper. Med. **79**: 539, 1944.

with this antigen in acute hepatitis. Our results do indicate an elevated presumptive titer (1:320) early in the illness and a prompt fall to 1:80 within the next week. The absorption with boiled guinea pig kidney was complete at all stages of the illness, and the boiled ox erythrocytes consistently showed incomplete absorptions. Therefore, the heterogenetic antibody acted here like the normal Forssman antigen and could be differentiated from that characterizing infectious mononucleosis. The human liver tests, employing both boiled and unboiled liver antigen, reflected little or no absorption of the antibody.

TABLE 2.—*Heterophil Antibody Absorption Studies in the Case Reported*

Date (1948)	Sheep Cell Agglutination Titer	Titer Following Absorption By: Guinea Pig Kidney	Ox Cells	Human Liver
9/22	1:320	0	1:80	1:160*
9/27	1:80	0	1:20	Hemolysis †
10/ 6	1:80	0	1:40	1:80*
10/19	1:80	0	1:40	Hemolysis †
12/21	1:80	0	1:40	1:80* 1:80†

* Boiled. † Unboiled.

SUMMARY

A case of serum-transmitted virus hepatitis in a 41 year old woman blood bank worker is reported. The mode of transmission was probably the accidental pricking of her hands and fingers during the withdrawal of needles from donors' arms and from receiving bottles after phlebotomies were completed. The hazard to other than the recipient of human blood products is emphasized. The physician and technician are cautioned against accidental self inoculation with the hepatitis virus by pricking of the skin while performing phlebotomies, venipunctures or injections in human beings. This case represents the first known instance in which a compensation award was granted for a virus hepatitis and introduces a new type of compensable occupational hazard. A heterogenetic antibody with the absorption characteristics of a Forssman antibody is identified in the serum of this patient.

RADIODERMATITIS OF THE LIP AFTER EXPOSURE TO ARC WELDING

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Control of the hazards of industry is the constant concern of the industrial surgeon. The early diagnosis of chronic lesions of the lip also commands attention, because cancer of the lip is frequently observed. In the 2 cases herein described there is a similar history of exposure to arc welding with the resultant formation of typical lesions of the lip. Since this condition has not been reported and has been an industrial hazard, it seems appropriate to record these cases.

REPORT OF CASES

CASE 1.—D. J. E., a sergeant aged 31, entered Fort Monmouth Station Hospital on May 18, 1948, because of a lesion of the lower lip on the left side. The condition had been noted by two medical officers, who advised biopsy.

The patient had noted a "scab" on the left side of his lower lip since November 1945. A crust about 3 mm. in diameter would form; this became hard and leathery on the third day and "looked dirty." The center then became depressed, with the edges frayed and projecting; at this time it would catch and bleed. By the end of the day it would fall off, leaving a hollow place surrounded with a white ring. Then the crust would commence to reform, and the cycle would be completed again by the fifth day. In the beginning the patient thought that the condition was a cold sore or came from a "bad stomach." Later he became concerned about the lesion.

It was noted that he had worked from September 1941 to March 1945 in shipyard construction as a shipfitter. His duties were to read blueprints while working among arc welders who were assembling ballast tanks. The welders protected their eyes and face by wearing hoods; this patient's protection consisted only of goggles for his eyes.

Past history related an operation for hernia in 1938 and an attack of urinary calculi in 1944. It was also noted that this

Fig. 1 (case 1).—Fissured, thickened lower lip three weeks after excision of the lesion.

patient had occasional dyspepsia. In the past, while a civilian, the patient had smoked as much as two and one-half packs of cigarets a day.

Examination revealed an adult who looked older than his stated age of 31. His complexion was ruddy, his lower lip displaying a lesion about 1 cm. from the commissure and about 3 mm. in diameter. The lesion was square, grayish brown and thicker than the rest of the lip. The entire lip seemed pallid and thickened, with distinct sharp creases in the membrane which ran radially from the vermilion border inward. Nutritional lesion and leukoplakia were considered. While the troublesome crust seemed benign, it was considered necessary to perform a biopsy in order to settle the diagnosis.

With the patient under local anesthesia a triangle of the lip was excised which removed the lesion. The wound was sewed up in three layers, mucous membrane, muscle and skin. The wound healed well without incident, and all sutures were removed by the fifth day. The patient made an uneventful recovery.

The pathologist reported that the epidermis showed thinning of the prickle cell layer, absence of rete pegs and slight hyperkeratosis. Below the epidermis the upper corium revealed basophilic degeneration of connective tissue and destruction of elastic fibers. Foci of lymphocytes were found throughout the corium. Small dilated capillaries were increased in number. The epithelium of the mucous membrane revealed marked hyperkeratosis. There were areas of parakeratosis. The granular cell layer was thickened. There was moderate acanthosis, but the rete pegs were flattened so that they lay in a flattened plexiform arrangement. Numerous small capillaries and vascu-

Fig. 2 (case 2).—Lesion and fissured lip before excision.

lar spaces which were present gave the area a telangiectoid appearance. Surplus epithelium, elastosis, basophilic degeneration of connective tissue and telangiectasia gave this lesion the appearance of radiodermatitis. The arc welders' light was considered a source of energy sufficient to have caused this lesion.

CASE 2.—B. L. M., a private aged 25, was admitted to the hospital on Aug. 17, 1948, complaining of an annoying lesion on the left side of his lower lip. There was no pain, itching

or burning, but constant irritation caused him to bite his lip. About six weeks before admission he had come to the surgical clinic complaining of the crust. The lesion was electrodesiccated, which gave him relief for a time after it healed. However, the condition recurred and he entered the hospital for excision of the lesion.

This patient had worked in his father's welding shop from the time he was 12 until he was 22 years of age. He was a part time helper and was "in and out of the shop all the time." There was a history of venereal warts for "the past two years." He had also been "bothered lately by plantar warts." He smoked one and one-half packages of cigarets a day and occasionally had shortness of breath; there was no history of heart trouble.

In 1934 a "wartlike growth" appeared near the right side of the lower lip and grew to the size of a match head, forming a crust in the course of two months. This lesion had been excised; it healed leaving a tiny scar.

On examination the lip was thickened, the vermilion border indistinct and the mucous membrane pallid. There were many vertical creases, especially near the corners and more pronounced on the felt. An irregular grayish yellow crust 4 mm. in diameter lay 1 cm. from the lateral commissure.

On August 18 the lesion was excised with the patient under local anesthesia; the wound was repaired in three layers. Healing occurred without event; sutures were removed by the fifth day.

The pathologist reported "radiodermatitis, a lesion that could have been caused by radiation exposure to roentgen ray, ultraviolet rays, excessive sunlight or arc welding."

COMMENT

These cases are reported because they show the effect of an industrial hazard on the lip to cause a typical lesion, possibly precancerous. The lesion in both cases was on the lower lip.

CUTANEOUS BURNS DUE TO FLUORESCENT LIGHT

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Fluorescent lighting has hitherto been considered entirely harmless. In December 1948 an informal request was submitted to the Medical Department of a large pharmaceutical manufacturing organization to investigate complaints of a mild type of cutaneous irritation occurring among the 5 female operators in the penicillin filling-room. These complaints were minor, for at no time had any of the affected employees reported to the plant dispensary for treatment, nor had any time been lost from work as a result of this condition.

Chief complaints of the operators were redness, dryness and occasional itching of the skin, most prominent on the forearms, arms and exposed areas of the neck and upper sternal region. Examination revealed erythematous areas, with dryness and some evidence of moderate desquamation. Lines of demarcation on the upper part of the arm at the edge of the sleeve were noted in 1 case.

Questioning revealed that these lesions were transient and that they disappeared over a week end or when the operator worked in a different area for a day or two. It was also stated that the lesions occurred only in this particular room and that when the affected operators worked on the same products in other locations, symptoms did not result. For the latter reason, contact dermatitis due to a particular drug sensitivity was immediately eliminated as a direct causative factor.

POSSIBLE CAUSATIVE FACTORS

The room where the exposure occurred was then carefully inspected. It is an enclosed room, measuring 12 by 14 feet (366 by 427 cm.), air conditioned in a closed system and lighted by recessed, shielded, fluorescent ceiling fixtures. In the room are two filling tables, each partially hooded by plexiglass sections. Inside of each hood is an ultraviolet sterile-lamp with shield and, suspended from the under side of the cabinet top, a fluorescent light for illumination. There is a shielded ultraviolet sterile-lamp over the door and another above the window on the wall opposite the door.

Ultraviolet Burn.—Having eliminated a drug sensitivity reaction as a causative factor, the next most likely possibility appeared to be ultraviolet burn. According to the standard

Fig. 1.—Erythematous area with sharp lines of demarcation at the neckline.

operating procedures in that department, the ultraviolet sterile-lamps were used only when no operators were in the room, such as during rest periods, lunch period and at night. The supervisor gave assurances to the effect that this procedure was being followed to the letter by the operating personnel. This was confirmed by repeated spot checks at irregular intervals. Since the ultraviolet lamps were not in use during times of occupancy, it was obvious that they could not directly be causing these lesions.

As a further check, however, the Safety Department was requested to measure the intensity of the ultraviolet radiation with all the lamps in operation. Readings taken at each work place indicated that the shields afforded the operators effective protection against ultraviolet radiation from the sterile-lamps.

Ozone Sensitivity.—Consideration was then given to the possibility of a dermatitis from ozone sensitivity. The type of ultraviolet lamp in use in this room created a not inconsiderable quantity of ozone, easily discernible by odor on entering the room. It was considered entirely possible that ozone was present at times in sufficient concentration to cause cutaneous sensitivity reactions.

Ozone itself is toxic when inhaled in sufficient amounts. For this reason, as well as for its possible role as a skin sensitizer, it was considered desirable to obtain readings of its concentration in the atmosphere of the room under actual working conditons.

The services of the Pennsylvania Bureau of Industrial Hygiene were requested for this study. Determinations were made of ozone concentrations under varying conditions of use of the ultraviolet lamps. Even after the lamps were permitted to operate all night and continuously during the test, the ozone concentration in the room never exceeded the accepted maximum allowable concentration (one part per million parts of air for an eight hour working day). In view of the findings, the field engineer of the bureau did not consider an ozone inhalation hazard to exist and consequently made no recommendations.

In cases of sensitivity dermatitis, however, even relatively minute quantities of a sensitizing agent may cause reactions. In an attempt to eliminate ozone as a causative factor, all ultraviolet equipment in the room was disconnected entirely for a period of two weeks. The cutaneous reactions continued in spite of this.

As a remotely possible source of ozone, the air-conditioning equipment was carefully inspected to discover the existence of any minor short circuit that might have created an arc, with

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the formation of ozone. No such arc was found, and the equipment was declared in excellent operating condition. Ozone, then, was eliminated as a source of the dermatitis.

No definite causative factors having as yet been determined, the filling room was again carefully examined, and an item by item comparison made with the other filling rooms in which cases of dermatitis had not occurred. The only significant mechanical difference in the rooms was the illumination of the hooded area of the filling tables by fluorescent tubes, as compared with ordinary incandescent lighting of the filling tables in the other rooms.

At the same time, a second examination of the affected workers toward the end of a day spent entirely in the penicillin filling room revealed bright erythematous areas on the exposed surfaces of the skin, with sharp lines of demarcation at the clothing edges. The affected areas presented a typical clinical picture of ordinary sunburn. The photograph of one of the affected operators (fig. 1) demonstrates such an area at the neckline. In order that comparison may be made with the worker's normal skin, the uniform at the neckline has been loosened and lowered somewhat from its normal position. Figure 2 also shows the V-shaped erythematous area at the neckline, as well as a roughened, finely desquamating area on the lateral surface of the arm and the dorsal surface of the forearm.

Although I had never seen or heard of cutaneous burns from ordinary fluorescent tubes, the physical and clinical evidence pointed directly to such a condition. At a working distance of only 10 to 14 inches (25 to 35 cm.), it seemed

Output in Watts for a 40 Watt (3,500° Kelvin Color Temperature) White Fluorescent Tube

Output	Range	Description
...	Below 2,800 A	Ultraviolet
0.01	2,800 to 3,200 A	Ultraviolet
0.1	3,200 to 3,800 A	Ultraviolet
1.6	3,800 to 5,000 A	Visible light
3.4	5,000 to 6,000 A	Visible light
3.0	6,000 to 7,600 A	Visible light
...	Above 7,600 A	Infra-red

entirely logical that small amounts of ultraviolet radiation from such a tube could be causing burns, provided that the exposure was sufficiently prolonged.

Each of the two cabinets in question contained one 20 watt, white fluorescent tube, uncovered except for a narrow metal glare-shield. This tube was in operation all during the production day, so that there was a possible worker-exposure of six to eight hours a day.

A request was forwarded to the manufacturer of the tube for performance specifications and spectral ranges emitted. From the information received, the following picture was constructed.

The shortest wavelength transmitted by a fluorescent tube is 2,800 angstrom units. Wavelengths shorter than this are absorbed by the glass of the tube. The output in watts through the spectral range is shown in the accompanying table.

This particular problem involves the 2,800 to 3,200 angstrom range—the so-called "tanning" or "burning" range. Since the tube in use was a 20-watt tube, there would appear to be an ultraviolet emission of 0.005 watts in the burning range. While admittedly minute in quantity, this amount of ultraviolet radiation at a working distance of only 10 to 14 inches (25 to 35 cm.) might, over a period of six to eight hours, produce a cutaneous condition of the type illustrated.

REVIEW OF THE LITERATURE

Search of the literature revealed only 1 pertinent report. James[1] listed 2 cases of dermatitis resulting from exposure to fluorescent light while at work. He described a female employee who exhibited a dermatitis about her face and eyelids, first noticed immediately after the installation of a single 40 watt daylight fluorescent tube 3 feet (91.4 cm.) above her desk. With the lamp turned off and without medical treatment, her skin returned to normal in two weeks. After three more weeks without symptoms, she worked under the light again for half a day and experienced a severe recurrence of her dermatitis. This employee was a brunette, who claimed to tolerate sunlight well.

In the second case also, a woman presented a dermatitis involving the back of her neck and her face, particularly the eyelids. Fluorescent lamps had been installed in her office just prior to the start of the symptoms. The installation was multiple in nature, consisting of four 40 watt daylight tubes placed at a distance of about 8 feet (244 cm.) from the worker's back. Although she was soon transferred to another office, she was still exposed to this radiation for ten to thirty minutes each day while consulting her files, and the dermatitis continued. Routine patch tests, including those for cosmetics, gave negative results. The patient stated that her skin itched and

Fig. 2.—Roughened, finely desquamating area on the lateral surface of the arm and the dorsal surface of the forearm; V-shaped erythematous area at the neckline.

burned for hours after each exposure to the fluorescent light. She was instructed to apply a tannic acid solution to the affected areas of the skin several times a day and to wear tinted polaroid glasses. Under this regimen, her cutaneous condition cleared up rapidly. Whenever she failed to apply the solution or to wear her glasses, the dermatitis reappeared. This patient was a blonde with fine, delicate skin. She stated that she normally avoided sunlight in the summer because her skin would not tolerate it.

The 2 patients of James seem to exhibit a genuine hypersensitivity to one or more of the bands of light emitted from fluorescent tubes. The greater working distances involved, plus the short periods of exposure, would appear to rule out the direct burning action of minute quantities of ultraviolet radiation, such as exists in these burns acquired in the filling room.

No other reports could be found in the literature on the occurrence of dermatitis or other dermatologic effects as a result of exposure to fluorescent light.

1. James, A. P. R.: Sensitivity of the Skin to Fluorescent Light, Arch. Dermat. & Syph. 44:256 (Aug.) 1941.

REMEDIAL MEASURES

With temporary acceptance of the premise that these filling-room operators were suffering from mild ultraviolet burns from fluorescent light, three remedial procedures appeared feasible:

1. To replace the fluorescent fixture with regular incandescent lighting. This was considered undesirable because of the quantity and quality of light required for proper performance of the work, because of the higher amount of heat produced by the incandescent bulbs and for maintenance reasons.

2. To have the affected operators use protective solutions, ointments or creams. This was considered undesirable because of possible contamination of the products being handled. In addition, use of such protective preparations requires interruption of work, is inconvenient for the operator and is difficult to enforce.

3. To guard the offending tube with an all-round plate-glass shield. This would absorb the offending ultraviolet radiation without decreasing the quantity of the illumination or materially altering its quality. In addition, it had the added benefits of requiring no effort on the part of the employee, and of not affecting in any way the products being handled.

Since the third method was obviously the most desirable, a ¼ inch (0.64 cm.) thick all-round plate-glass shield was constructed and installed about the offending tube in one of the two filling tables.

RESULTS

In two days, the operators at the table with the shielded tube were free of any cutaneous reaction, while the operators at the other table continued to display the same erythematous condition. When the operators exchanged tables, the first group, now at the unprotected table, rapidly exhibited the erythema again, while in the second group the condition just as quickly cleared up.

A similar plate-glass shield was constructed for the fluorescent tube in the other table, and the erythema among these operators disappeared entirely. The condition has not recurred.

COMMENT

These cases are of particular interest to physicians, since they point out a previously unrecognized hazard from fluorescent lighting. With the increasing use of fluorescent lighting, it is only logical to expect an increase in the number of persons who may react unfavorably to it.

Physicians should keep in mind the possibility that undesirable cutaneous reactions may follow prolonged exposure to fluorescent lighting at relatively short working distances.

1401 Magee Avenue (11).

Si Monumentum Requiris, Circumspice.—Let us recall that Sir Christopher Wren, to whom London owes St. Paul's Cathedral, The Middle Temple Gateway, and many celebrated churches now destroyed by bombs, was an LL.D. of Oxford, who studied and practiced medicine in the City of London. It is recorded that when studying medicine at Oxford he was the first to advocate intravenous injections and watch the effect of injected wine and beer into the veins of dogs, and later he experimented with opium and other drugs on human beings. Wonderful plates illustrating the anatomy of the brain are memorials of his scientific attainments which eventually gave way to architecture. It is a matter of pride to remember that Wren at the height of his celebrity as an architect stayed in London along with Samuel Pepys (when most of their colleagues had fled) while the Great Plague raged, the one reverting to his original profession, the other thinking only of his beloved Navy and the thereatened Dutch Invasion. In Christopher Wren surely the Debt of the Fine Arts to Medicine is well exemplified. So let us remember the epitaph on his tomb in St. Paul's: "Si Monumentum Requiris, Circumspice."—V. B. Green-Armytage, M.D., The Debt of the Fine Arts to Medicine, *Cambridge University Medical Society Magazine*, Easter term, 1949, Reprinted from "The Embryo," Summer, 1947.

Council on Pharmacy and Chemistry

REPORT TO THE COUNCIL

The Council has authorized publication of the following report from the Therapeutic Trials Committee, a standing committee of the Council on Pharmacy and Chemistry.

AUSTIN SMITH, M.D., *Secretary.*

EFFECTIVENESS OF CHLORESIUM IN WOUND HEALING AND DEODORANT EFFECTS

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and
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Of the various considerations in the management of wounds, those in which clinicians are generally interested are the rate of healing and the odor and appearance of the wound. Many attempts have been made in past decades to introduce new therapeutic agents which would improve the progress of one or all of these qualities. Yet, the multitude of preparations alone suggests that not one of them has been uniformly successful.[1]

Recently, the water-soluble derivatives of chlorophyll have received enthusiastic support for their beneficial effects on various types of wounds. The clinical reports concerning chlorophyll therapy were impressive enough to stimulate our interest in following its effect on the course of various types of wounds at the Hospital of the University of Pennsylvania. For many years the Surgical Clinic and the Harrison Department of Surgical Research have been interested in the healing process. Thus, it was hoped, in spite of past unsuccessful attempts by many investigators, that perhaps an agent at last had been found which would uniformly promote wound healing.

This communication is a report of the use of chorophyll therapy in the management of wounds. It encompasses a study of 36 patients in whom special attention was given to the rate of wound healing and to wound odor and appearance. Forty-two cases were originally included in the project, but 6 of these cases have been discarded from the present series because of either the patients' failure to return or the intervention of other therapeutic measures which invalidated the results.

RATE OF WOUND HEALING

Since no substance has been found to date uniformly to promote and accelerate wound healing and in view of other convincing experimental evidence, most investigators believe that strict adherence to sound surgical principles is more important than the application of any substance in the process of wound healing and that the use of various agents prepared for the local treatment of wounds should not be considered a substitute for good wound care.[2] Emphasis has thus been placed on the importance of asepsis, the gentle handling

Several tables and illustrations have been omitted to conserve space; these will be included in the reprints.

From the Harrison Department of Surgical Research Schools of Medicine, University of Pennsylvania and the Surgical Clinic of the Hospital of the University of Pennsylvania, Philadelphia.

The investigation was conducted under the auspices of The Therapeutic Trials Committee of The Council on Pharmacy and Chemistry pursuant to a contract between The Rystan Co., Inc., and The University of Pennsylvania.

1. (*a*) Smelo, L. S.: Arch. Surg. **33**: 493 (Sept.) 1936. (*b*) Brush, B. E., and Lam, C. R.: Surgery **12**: 355, 1942. (*c*) Williams, R. H., and Bissell, G. W.: Arch. Surg. **49**: 225 (Oct.) 1944.

2. (*a*) Smelo.[1a] (*b*) Zintel, H. A.: Surg. Clin. North America 1404-1415 (Dec.) 1946. (*c*) Churchill, E. D.: Ann. Surg. **120**: 268, 1944.

of tissue, excision of all devitalized tissue and the preservation of the local blood supply. Not only rigorous care of the local wound, but also consideration of the general condition of the patient has been repeatedly stressed by numerous authors.[3]

Several publications in the last few years have reported that chlorophyll derivatives possess tissue-stimulating properties.[4] Smith and Livingston,[4a] in a series of 1,372 experimental lesions produced in animals and treated with chlorophyll, showed healing time to be decreased by approximately 25 per cent in over two thirds of the animals. These results, together with other clinical reports concerning chlorophyll therapy,[5] have prompted the present study of testing objectively its effect on the healing rate of wounds in man.

METHOD

It was realized from the very first that the evaluation of a new agent of this type is a difficult task. Variables introduced by numerous extraneous local and general factors may readily mislead the investigator to unjustifiable conclusions. Furthermore, one must avoid the use of clinical impressions of the encouraging response of the wound to the application of the local agent. To use such clinical impressions, even though compared with the effects of other materials used alternately or after a previous period of resistance to healing, is to introduce errors that readily invalidate the results of the study. It is evident then, as Smelo [1a] pointed out over a decade ago, that reliable assessment of the so-called wound stimulant requires more accurate methods of evaluation than those generally employed. The problem demands a quantitative approach.

Such a quantitative method was provided by the studies of Carrel and Hartman,[6] who demonstrated that superficial wound repair in man occurs according to a regular geometric curve which may be expressed by a mathematic equation in function of area and time. Du Noüy's [7] formula of these relationships permits the prediction of the period in which a wound should normally heal and the calculation of the expected area of the wound at any time during the course of repair. By determining the normal rate of healing one is thus more qualified to take into consideration the variables that may speed or retard tissue repair.

The method of Smelo [1a] was utilized to determine the precise measurements of the surface area of the wound each time it was dressed. The area was obtained by placing a transparent celluloid film directly on the wound and tracing the line of union between the epithelial edge and the granulating surface. This tracing was then transferred to a sheet of paper and the area determined with a planimeter.

Cultures were taken at frequent intervals to follow the effect of the chloresium preparations on the bacteriologic makeup of the wounds. Quantitative dilution methods were not employed, in view of the convincing work of Anderson,[8] who showed that decreased bacterial counts do not in themselves tend to promote wound healing.

The investigation on healing was carried out on 25 patients, all in good general health unless otherwise stated. The wounds differed in size and etiologic aspects. Every effort was made to determine the presence of any factor remote from the site of the wound which may have unduly influenced the local changes in healing. In the series of patients treated, 11 had infected wounds, 3 had surgically clean wounds, 3 had burns, 6 had lesions resulting from venous stasis and 2 had ulcers due to sickle cell anemia.

Chloresium ointment in moderately generous quantities was applied to a square gauze dressing, which was placed over the wound and held there with simple bandaging. Dressings were changed every other day. When necessary, local débridement of devitalized tissue was performed. Nineteen of the 25 patients were treated as outpatients. The remainder were ward patients with ambulatory privileges for all but 2 patients.

RESULTS

In this investigational study, the terms "accelerated," "normal" and "retarded" with respect to healing time have the following definitions: Accelerated means the time of healing was faster, normal means the time was equal, and retarded means that the time was slower than was theoretically expected by du Noüy's formula.

The series of patients is divided into two groups on the basis of whether complete healing was achieved during the course of therapy. Of the 25 patients, 18 in the first group were still receiving chlorophyll therapy when the project was stopped for evaluation (table 1). In the second group are the 6 patients who achieved complete healing of their wounds prior to cessation of the study (table 2). In addition, 1 other patient experienced a sensitivity skin reaction to the chloresium ointment, and therapy was discontinued before adequate data were available. Analysis of the results in the first group reveals that 14 patients had retarded healing, 2 normal healing and 2 accelerated healing. These results were classified on the basis of a comparison between the actual measured surface area and the theoretically expected surface area after the respective days of healing as calculated by du Noüy's [7] formula. A deviation of plus or minus 10 per cent from the calculated area was considered within the range of normal healing. Of the 2 patients whose wound showed accelerated healing, 1 had a wound following a recurrent abscess of the thigh and the other had a burn.

TABLE 5.—*Interpretation of Quantitative Results*

Term Used	4+	3+	2+	1+
Excellent	0	...	...	...
Very effective	1+	0	...	...
Satisfactory	2+	1+	0	...
Equivocal	3+	2+	1+	0
No benefit	4+	3+	2+	1+

The results of wound healing in patients of the second group were determined by a comparison of the actual time with the theoretically expected time required for complete wound healing. Of the 6 patients in this group, 1 had retarded healing, 2 had normal healing and 3 had accelerated healing. Likewise in this group a deviation of plus or minus 10 per cent was considered within the normal range. The instances of accelerated healing in this group occurred in 1 patient with an ulcer resulting from a furuncle, in another with an ulcer due to venous stasis and in the third with a lesion resulting from a burn.

3. Zintel.[3b] Thompson, W. D.; Ravdin, I. S., and Frank, I. L.: Arch. Surg. **36**: 500 (March) 1938. Hartzell, J. B.; Windfield, J. M., and Irvin, J. L.: J. A. M. A. **116**: 669 (Feb. 22) 1941. Rhoads, J. E., and Kasinskas, W.: Surgery **11**: 38, 1942. Sanders, G. B., and Garrison, W. S.: Arch. Surg. **46**: 40 (Jan.) 1943.
4. (*a*) Smith, L. W., and Livingston, A. E.: Am. J. Surg. **62**: 358, 1943. (*b*) Smith, L. W.: J. Lab. & Clin. Med. **29**: 241, 1944.
5. Bowers, E. F.: Am. J. Surg. **73**: 37, 1947. Boehme, E. J.: Lahey Clin. Bull. **4**: 242, 1946. Morgan, W. S.: Guthrie Clin. Bull. **16**: 94, 1947. Cady, J. B., and Morgan, W. S.: Am. J. Surg. **75**: 562, 1948.
6. Carrel, A., and Hartman, A.: J. Exper. Med. **24**: 429, 1916.
7. DuNouy, P. J.: J. Exper. Med. **24**: 461, 1916.
8. Anderson, D. P.: Ann. Surg. **108**: 918, 1938.

Untoward reactions to chloresium consisted primarily of slight itching, which was noted in 6 patients. In 1 of 2 other patients in whom vesicular eruptions occurred with use of chloresium, 1 patient was known to have a definite allergic background. Treatment should be discontinued if redness or itching appear during treatment.

In 3 out of 10 instances the chloresium ointment may have had bacteriostatic activity. The organisms affected included hemolytic Staphylococcus aureus, alpha and beta streptococci and an unidentified gram-negative rod.

COMMENTS

In an attempt to quantitate the effect of chlorophyll therapy on wound healing, it is believed that a more accurate means of evaluation has been used than in previous reports. In the series herein reported ideal quantitative evaluation was not possible because of the limitations of the du Noüy formula. Yet, what has been completed with the use of this formula is considered a more accurate evaluation than clinical observations even with attempted controls. The phenomenon of wound healing is notable for its complexity and inherent variables, and clinical observations do not usually consider the differential effect of these variables on the healing process. The advantage of one's using the du Noüy formula lies in the recognition of two of the most significant of these variables, the age of the patient and the size of the wound. Other variables known to influence the process of wound healing,[2b] but not expressed in the du Noüy formula, include the following, which may be grouped under two headings: (1) general status of the patient—hypoproteinemia, vitamin deficiency (A, C or K), electrolyte and water balance, anemia or systemic infection—and (2) local factors—tissue trauma, presence of devitalized tissue at the wound site, local temperature and integrity of the blood supply.

It is therefore necessary to establish some quantitative relationship between the rate of wound healing and these other variables even though it is a difficult task. In the evaluation of the results in the present study, the factors listed herein under general conditions of the patient by a careful clinical survey were not considered significant variables in 20 of the 24 patients. Of the 4 patients in whom a general factor was considered significant, 2 patients had sickle cell anemia and 1 patient a positive serologic reaction, and all were found to have retarded healing by our study. The other patient had hypoproteinemia, yet unexpectedly was found to have accelerated wound healing.

Of the local factors listed, variations in temperature of the local part was not thought to be of significance in this group of patients. Tissue trauma, on the other hand, appeared to be an influencing factor in 1 patient with a decubitus ulcer following a burn over the sacrum, but healing time was normal. In regard to presence of devitalized tissue, every attempt was made completely to eliminate it from the wound site, and this was successful in most instances. In 4 patients it is possible that devitalized tissue was not so thoroughly removed as to eliminate its influence on the healing process. Three of these 4 patients had retarded healing; 1 had accelerated healing.

The last of the local factors listed, the integrity of the blood supply, is the major significant variable that was not adequately evaluated by our study and represents an important limitation to the completion of an accurate quantitative evaluation of chlorophyll as a wound stimulant in man. It was hoped that the accumulation of a very large series of control cases would provide corrective factors to the du Noüy formula to overcome this limitation, and such an attempt was made. However, because of the wide range of results obtained, no definite relationship could be established.

TABLE 6.—*Calculations for the Group of Patients Whose Wounds Did Not Heal to Completion During the Course of Chlorophyll Therapy*

Patient	Age	S(o), Sq. Cm.	T (Healing Days)	T‡	I*	B†	$\frac{I}{B} = K$	B′†	$\frac{100}{B'} = 2P$	The du Noüy Formula $\log S(T) = \log S(o) - K\left(T + \frac{T^2}{2P}\right)$	S(T) Theoretically Expected Area in Sq. Cm. After	S(T) Actual Measured Area in Sq. Cm. After	Interpretation of Rate of Wound Healing‡
											T Days	T Days	
B. H.	46	5.16	34	1156	0.0708	1.19	0.05950	1.453	68.82	7.6896-10	Less than 0.4§	2.19	Retarded
H. H.	69	3.94	25	625	0.0700	1.19	0.05880	1.450	68.97	8.5920-10	Less than 0.4§	1.80	Retarded
G. D.	21	43.34	26	676	0.0420	1.34	0.03130	1.325	75.40	0.545	3.51	23.35	Retarded
A. E.	71	9.35	25	625	0.0200‖	1.45	0.01380	1.230	81.30	0.5289	3.38	1.61	Accelerated
W. Y.	32	2.64	9	81	0.0700	1.19	0.05880	1.450	68.97	9.8233-10	0.67	1.23	Retarded
J. P.	37	22.06	23	529	0.0346	1.37	0.02530	1.290	77.40	0.5888	3.88	5.81	Retarded
C. B.	61	27.74	36	1296	0.0200‖	1.45	0.01380	1.230	81.30	0.7264	5.324	25.03	Retarded
M. C.	22	5.89	2		Untoward Sensitivity Reaction—Data Insignificant								
J. C.	15	1.29	30	900	0.0800	1.14	0.0702	1.490	67.12	7.7264-10	Less than 0.4§	0.52	Retarded
R. L.	32	7.74	22	484	0.0618	1.23	0.05015	1.413	70.78	9.4410-10	Less than 0.4§	2.58	Retarded
J. W.	55	7.81	11	121	0.0445‖	1.32	0.03360	1.335	74.90	0.4689	2.94	7.61	Retarded
H. W.	72	25.88	16	256	0.0200‖	1.45	0.01380	1.230	81.30	1.1488	14.08	14.19	Normal
M. D.	29	3.35	7	49	0.0710	1.19	0.05890	1.454	68.80	0.1844	1.53	1.16	Accelerated
C. G.	61	4.13	27	729	0.0700	1.19	0.05880	1.450	68.97	8.4065-10	Less than 0.4§	4.39	Retarded
F. B.	60	184.50	41	1681	0.0200	1.45	0.01380	1.230	81.30	1.4148	25.98	157.40	Retarded
R. C.	28	9.99	22	484	0.0640	1.22	0.05245	1.420	70.41	9.4856-10	Less than 0.4§	5.29	Retarded
M. M.	62	34.25	5	25	0.0200‖	1.45	0.01380	1.230	81.30	1.4608	28.90	30.12	Normal
R. R.	30	9.22	34	1156	0.0716	1.18	0.06070	1.460	68.59	7.8777-10	Less than 0.4§	0.71	Retarded
P. B.	48	11.35	17	2890	0.0328‖	1.38	0.02376	1.287	77.70	9.7746-10	0.595	1.61	Retarded

* Index of healing (see table 3).
† A factor obtained from figure 2.
‡ Determined by a comparison of the theoretically expected area to the actual area measured after T days of healing.
§ When the calculated area of the wound is 0.4 sq. cm. or less, the wound is considered to be healed.
‖ Extrapolated values (see figure 1).

With the method used, the variability was too great to lend itself to a quantitative approach.

ODOR AND APPEARANCE OF THE WOUND

By contrast to the objective approach of the section of rate of wound healing, a study of the effect of chloresium on the odor and general appearance of a wound, by necessity, requires subjective evaluation. It is recognized that there is a wide range of opinion in reference to odor. Yet, the average of a group of opinions, it was decided, should more closely approximate the true effect than any other known method. An arbitrary quantitative estimation of the intensity of odor of the wound was therefore used as a measure of the effect of chlorophyll therapy. This system ranged from 0 for absence of odor to 4 plus for maximum odor. At least three and up to six opinions were obtained from various staff personnel and the average taken as representative of the final evaluation.

In the series of 11 patients studied (table 4), 7 patients had abdominoperineal resections, in 6 of whom chloresium solution was used to irrigate the posterior perineal wound daily after the packing was removed on the eighth day. The other patient, with an abdominoperineal resection of six years' duration, returned for fulguration of a recurrent rectal carcinoma and for a left anterolateral cordotomy for relief of pain. Two patients had a transverse colostomy; 1 patient had a draining abdominal fistula, and 1 patient had an ulcerating bronchogenic carcinoma. There was also daily use of chloresium solution with the change of dressings in these latter cases. Table 5 shows the means by which the quantitative results were interpreted in descriptive terms. Six of the patients acted as their own controls, with the use for varying periods of time of dry dressings, saline irrigations or chloroazodin (azochloramid*). Additional controls were obtained from similar types of wounds in different patients. With respect to the control series as a whole, chlorophyll therapy was shown consistently to decrease the odor of foul-smelling wounds, and it did so, on the average, within twenty-four to forty-eight hours. No untoward reactions were noted in this group of patients.

Of the 7 patients with abdominoperineal resections, chloresium solution was very effective in 5 and satisfactory in the other 2 patients. Of the 2 patients with transverse colostomy, 1 patient received very effective and the other satisfactory benefit. The patient with a draining abdominal fistula had a satisfactory therapeutic result and the patient with the ulcerating bronchogenic carcinoma a very effective decrease in odor with the use of chlorophyll therapy. In 1 patient with an abdominoperineal resection, chloroazodin was almost as effective a deodorant as chloresium but had the disadvantage of causing local irritation.

In reference to wound appearance, it was the almost unanimous opinion of those concerned with the project that the chloresium ointment tended to produce a clean granulating wound. Regardless of the effect on the healing rate, the wounds had a healthy pink appearance and, in general, looked exceptionally good.

SUMMARY

In a study of the effect of chlorophyll therapy on the rate of wound healing, various types of wounds were closely observed. With reference to the du Noüy formula, chlorophyll therapy was associated with acceleration of healing in 5 out of 24 patients. In 3 of these 5 patients, local or general factors known to impede the healing process were present. The wounds of 4 patients healed in the normal expected time, in 2 of whom healing was influenced by local factors. The remainder, 15 patients, had a rate of healing less than the theoretical by the du Noüy formula; of these, 13 had either local or general factors present.

These results, while not uncontroversial, suggest that chlorophyll therapy is not a consistent promoter in every case of wound healing within the time limits expected under du Noüy's formula. To do so an agent should be able uniformly to reduce the expected time of healing in every case in all types of wounds.

Chlorophyll therapy did not give any evidence of retarding wound healing.

Chlorophyll was found consistently to be an effective deodorant when used on foul-smelling wounds. Untoward effects of chlorophyll occurred in a minimal number of patients and consisted mostly of itching. Chlorophyll therapy did tend to improve the appearance of wounds and give them a healthy granulating appearance.

TABLE 7.—*Calculations for the Group of Patients Whose Wounds Healed to Completion with Chlorophyll Therapy*

Patient	Age	S(o), Sq. Cm.	S(T), Sq. Cm.	$\frac{S(o)}{S(T)}$	$\log \frac{S(o)}{S(T)}$	I*	B†	$\frac{1}{B} = K$	B'†	$\frac{100}{B'} = 2P$	P	Calculated Time for Normal Expected Wound Healing ‡ $\frac{-PK \pm \sqrt{PK\left[PK + 2\log\frac{S(o)}{S(T)}\right]}}{K}$	Actual Time Required for Complete Healing, Days	Interpretation of Rate of Wound Healing §
S. C.	55	4.52	0.4	11.300	1.05310	0.0700	1.1900	0.05880	1.450	68.97	34.49	15.30	12	Accelerated
E. M.	43	19.63	0.4	49.070	1.69080	0.0290‖	1.4030	0.02967	1.270	78.74	39.37	18.50	17	Normal
N. R.	39	6.77	0.4	16.925	1.22855	0.0618	1.2325	0.05015	1.413	70.78	35.39	19.25	19	Normal
R. A. R.	54	9.09	0.4	22.730	1.35660	0.0380‖	1.3660	0.02794	1.310	76.32	38.16	14.70	9	Accelerated
L. O.	66	13.67	0.4	34.175	1.53370	0.0200‖	1.4500	0.01380	1.230	81.30	40.65	62.70	27	Accelerated
M. C.	53	4.26	0.4	10.650	1.02730	0.0700	1.1900	0.05880	1.450	68.97	34.49	12.50	17	Retarded

* Index of healing (see table 3).
† A factor obtained from figure 2.
‡ Equation derived from the original du Noüy formula of $\log S(T) = \log S(o) - K\left(\frac{T + T^2}{2P}\right)$
§ Determined by a comparison of the theoretically expected time to the actual time required for complete wound healing.
‖ Extrapolated value (see fig. 1).

NEW AND NONOFFICIAL REMEDIES

The following additional articles have been accepted as conforming to the rules of the Council on Pharmacy and Chemistry of the American Medical Association for admission to New and Nonofficial Remedies. A copy of the rules on which the Council bases its action will be sent on application.

AUSTIN SMITH, M.D., *Secretary.*

AMOBARBITAL SODIUM (See New and Nonofficial Remedies 1949, p. 452).

The following dosage form has been accepted:

ELI LILLY AND COMPANY, INDIANAPOLIS 6

Amytal Sodium: 0.75 Gm. ampuls.

U. S. trademark 161,125.

CONTRACEPTIVE JELLIES AND CREAMS (See New and Nonofficial Remedies 1949, p. 285).

The following dosage form has been accepted:

LANTEEN MEDICAL LABORATORIES, INC., CHICAGO 10

Lanteen Jelly: 85.35 Gm. collapsible tubes. A water dispersible jelly having a p_H of 5.2, prepared from the formula:

	Per Cent
Ricinoleic acid	0.50
Hexylresorcinol	0.10
Sodium benzoate	0.20
Chlorothymol	0.00769
Gum tragacanth	1.73
Starch	0.97
Hydrochloric acid	0.043
Calcium hydroxide	0.0264
Perfume	0.0126
Water sufficient to make	100.00

Packaged with applicator or as a refill without applicator.

Lanteen Applicator: A transparent plastic tube threaded to screw onto the tubes of Lanteen Jelly to permit filling by compression of the tube.

DIGITOXIN-U. S. P. (See New and Nonofficial Remedies 1949, p. 267).

The following dosage forms have been accepted:

ELI LILLY AND COMPANY, INDIANAPOLIS 6

Tablets Crystodigin: 0.05 mg. and 0.15 mg.

THE UPJOHN COMPANY, KALAMAZOO 99, MICH.

Tablets Digitoxin: 0.1 mg. and 0.2 mg.

WYETH, INCORPORATED, PHILADELPHIA 3

Tablets Purodigin: 0.15 mg.

U. S. trademark 411,271.

ESTROGENIC SUBSTANCES (WATER INSOLUBLE) (See New and Nonofficial Remedies 1949, p. 367).

The following dosage forms have been accepted:

BIO-INTRASOL LABORATORIES, INC., BROOKLYN 3, N. Y.

Solution Natrovin in Oil: 10,000 I. U. per cc. in sesame oil, 1 cc. ampuls and 30 cc. vials. Preserved with chlorobutanol 0.5 per cent.

KREMERS-URBAN COMPANY, MILWAUKEE 1

Solution Estrugenone in Oil: 5,000 I. U. per cc. in sesame oil, 1 cc. ampuls. Preserved with chlorobutanol 0.5 per cent.

CARROLL DUNHAM SMITH PHARMACAL COMPANY, NEW BRUNSWICK, N. J.

Aqueous Suspension Estrusol: 50,000 I. U. per cc., 5 cc. and 15 cc. vials. Preserved with chlorobutanol 0.5 per cent.

FOLIC ACID (See New and Nonofficial Remedies 1949, p. 559).

The following dosage form has been accepted:

EATON LABORATORIES, INC., NORWICH, N. Y.

Tablets Folic Acid: 5 mg.

MANNITOL HEXANITRATE (See New and Nonofficial Remedies 1949, p. 273).

The following dosage form has been accepted:

EATON LABORATORIES, INC., NORWICH, N. Y.

Tablets Mannitol Hexanitrate: 30 mg.

MERCUROPHYLLINE INJECTION-U. S. P. (See New and Nonofficial Remedies 1949, p. 317).

The following dosage forms have been accepted:

KREMERS-URBAN COMPANY, MILWAUKEE 1

Solution Mercurophylline: 62 mg. per cc., 5 cc. ampuls. Each 5 cc. contains 80 mg. of mercury as the mercurial salt.

Solution Mercurophylline with Benzyl Alcohol 2%: 155 mg. per cc., 2 cc. ampuls. Each 2 cc. contains 80 mg. of mercury as the mercurial salt.

METHIONINE (See New and Nonofficial Remedies 1949, p. 415).

The following dosage form has been accepted:

ABBOTT LABORATORIES, NORTH CHICAGO, ILL.

Tablets Methionine: 0.5 Gm.

PENICILLIN (See New and Nonofficial Remedies 1949, p. 148).

The following dosage forms have been accepted:

CHAS. PFIZER & CO., INC., BROOKLYN 6

Crystalline Procaine Penicillin G in Oil: 300,000 units per cc. in sesame oil, 1 cc. vial.

STERONE CHEMICAL CO., INC., JAMAICA 2, N. Y.

Crystalline Procaine Penicillin G (Micronized) in Oil: 300,000 units per cc. in sesame oil with aluminum monostearate 2 per cent, 10 cc. vials.

STREPTOMYCIN (See New and Nonofficial Remedies 1949, p. 159).

The following dosage form has been accepted:

BIO-RAMO DRUG CO., BALTIMORE 1

Streptomycin Calcium Chloride Complex: 20 cc. vials containing streptomycin calcium chloride complex equivalent in activity to 1 Gm. of streptomycin base.

SULFADIAZINE-U. S. P. (See New and Nonofficial Remedies 1949, p. 134).

The following dosage form has been accepted:

MARVIN R. THOMPSON, INC., STAMFORD, CONN.

Suspension Sulfadiazine with Sodium Lactate: 473 cc. and 3.78 liter bottles. A liquid suspension containing 0.5 Gm. sulfadiazine and 1.5 Gm. sodium lactate per 5 cc.

SULFADIAZINE-SULFAMERAZINE COMBINED (J. A. M. A., May 7, 1949, p. 21).

The following dosage forms have been accepted:

PITMAN-MOORE COMPANY, INDIANAPOLIS 6

Magmoid Sulfadimer with Sodium Lactate: 0.5 Gm. per 5 cc., 59.15 cc., 354.9 cc. and 3.78 liter bottles. A suspension containing 1.5 Gm. sulfadiazine, 1.5 Gm. sulfamerazine and 3 Gm. sodium lactate per 30 cc. solution.

THE WARREN-TEED PRODUCTS COMPANY, COLUMBUS 8, OHIO

Suspension Bi-Sulfazine: 0.5 Gm. per 5 cc., 473 cc. and 3.785 liter bottles. A suspension containing 1.5 Gm. sulfadiazine and 1.5 Gm. sulfamerazine per 30 cc. solution.

TESTOSTERONE PROPIONATE-U. S. P. (See New and Nonofficial Remedies 1949, p. 407).

The following dosage forms have been accepted:

RARE CHEMICALS, INC., HARRISON, N. J.

Solution Testosterone Propionate in Oil: 10 mg. per cc. in sesame oil, 10 cc. vials. Preserved with phenyl mercuric borate 1:50,000.

Solution Testosterone Propionate in Oil with Benzyl Alcohol 3%: 50 mg. per cc. in sesame oil, 10 cc. vials. Preserved with phenyl mercuric borate 1:50,000.

SMITH-DORSEY COMPANY, LINCOLN, NEB.

Solution Testosterone Propionate in Oil with Benzyl Alcohol 3%: 25 mg. per cc. in persic oil, 10 cc. vials.

***d*-TUBOCURARINE CHLORIDE** (See New and Nonofficial Remedies 1949, p. 210).

The following dosage form has been accepted:

ENDO PRODUCTS, INC., RICHMOND HILL 18, N. Y.

Solution *d*-Tubocurarine Chloride: 3 mg. (20 units) per cc., 10 cc. vials. Preserved with chlorobutanol 0.5 per cent.

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Council on Physical Medicine and Rehabilitation

The Council on Physical Medicine and Rehabilitation has authorized publication of the following reports.

HOWARD A. CARTER, *Secretary.*

CARDIOTRON, MODEL PC-2, ACCEPTABLE

Manufacturer: Electro-Physical Laboratories, Inc., 290 Dyckman Street, New York 34.

The Cardiotron, Model PC-2, is a direct-writing electrocardiograph in a portable case. As normally supplied it operates on 60 cycle alternating current at 100 to 130 volts. It draws a current of 0.85 ampere.

The dimensions of the cabinet are 22 by 31 by 37 cm. (8¾ by 12 by 14⅝ inches). Rubber bumpers add ½ inch to the height and width, and a carrying handle adds ⅞ inch to the width. The complete assembly, including all accessories, weighs 14.5 Kg. (32 pounds); the shipping weight is 20 Kg. (45 pounds).

Cardiotron, Model PC-2

The accessories are one 7-lead patient cable, four large electrodes, three small electrodes, four wrist bands, a chest band, tube of electrode jelly, roll of Permograph paper and reel, ground wire, emery board, two spare power line fuses, power cable, electrode jelly brush and protective cloth covering.

The apparatus was tested both physically and clinically in laboratories acceptable to the Council, and was found to satisfy the published requirements for acceptance of electrocardiographs. The Council on Physical Medicine and Rehabilitation voted to include the Cardiotron, Model PC-2, in its list of accepted devices.

MCKESSON WATERLESS METABOLOR, MODEL 185, ACCEPTABLE

Manufacturer: McKesson Appliance Company, 2226-2236 Ashland Avenue, Toledo 10.

The McKesson Waterless Metabolor, Model 185, is a bellows type apparatus with an electrically driven timing device. The bellows is circular in form and opens somewhat like a book; it is completely housed within a white case, so that its movements are evident only to the technician by way of a pointer called the Bellows Position Indicator. A soda lime container is mounted outside the Metabolor proper so as to facilitate the removal of exhausted absorbent; a color indicator in a small glass cylinder where it can be seen by the technician changes from bright green to dark brown when the soda lime approaches saturation with carbon dioxide.

The weight of the apparatus is given as 30 Kg. (65 pounds) and the over-all dimensions are 112 by 43 by 58 cm. (44 by 17 by 23 inches). Accessories include ink, two face hoods, head harness, two mouthpieces, a nose clamp, a tank wrench, a spanner wrench and a nomographic calculator made of cardboard. The shipping weight is 34 Kg. (75 pounds). The motor in the Metabolor submitted to the Council required a 110 volt alternating current and drew 2 watts of power, but the firm states that this unit is manufactured for all voltages and cycle frequencies ordinarily encountered in alternating current and also for direct current.

This device has a disadvantage which it shares with other waterless metabolimeters already accepted by the Council; namely, that it is difficult to verify the correctness of the volume readings. It is inconvenient to measure directly the volume of air expelled when the bellows is compressed, and practically impossible to calculate it. This is deplorable in view of the low reliability of basal metabolic rates, as noted in THE JOURNAL, March 22, 1941, pages 1187 to 1195, and the *Quarterly Bulletin, Northwestern University Medical School* (19: 105-110, 1945). It also impairs the value of waterless metabolimeters as equipment for demonstration and teaching. However, the fact that friction is less in a bellows and that the patient cannot see the movements inside the housing probably makes for a smoother respiratory tracing.

The Council on Physical Medicine and Rehabilitation voted to include the McKesson Waterless Metabolor, Model 185, in its list of accepted devices.

NEGATIVE PRESSURE SINUS UNIT ACCEPTABLE

Manufacturer: Inhalational Equipment Company, 248 East 119th Street, New York 35.

The Negative Pressure Sinus Unit is a device made of Pyrex glass and designed to connect with various accessories (oxygen tank, oxygen regulator, rubber hand bulb, nebulization foot pump, tubing and stoppers) in such a way that an intermittent suction can be produced in the nasal passages and accessory sinuses; the periodic release of the suction is intended to cause a brief influx or puff of aerosol into the sinuses. Frequent alternations between suction and normal pressure will produce a series of inflows of medicated air into the sinuses until a considerable amount of aerosol is introduced.

The weight of the device is about 85 Gm. (3 ounces); the shipping weight is about 200 Gm. (7 ounces), and the over-all dimensions are 23 by 23 by 8 cm. (9 by 9 by 3 inches).

The Council secured evidence that this device produces a satisfactory mist and that with its use medication can be induced to enter a sinus if the aperture is patent. The Council, therefore, voted to include the Negative Pressure Sinus Unit in its list of accepted devices with the understanding that the claims for any drugs used with this unit be confined to those found acceptable by the Council on Pharmacy and Chemistry.

DWYAD PORTABLE OXYGEN UNIT FOR AEROSOL MEDICATION ACCEPTABLE

Manufacturer: The Penicillin Machine Company, Box 751, Cleveland 22.

The Dwyad Portable Oxygen Unit for Aerosol Medication is a device that uses compressed oxygen from a tank for the purpose of nebulizing aqueous medicaments. It consists of a light weight nonshatterable tank with working mechanism attached to the nebulizer, so that the inhalation can be taken in through either mouth or nose as desired.

The assembly weighs 4.5 Kg. (10 pounds), and the shipping weight is 5.4 Kg. (12 pounds). The over-all dimensions are 20 by 20 by 89 cm. (8 by 8 by 35 inches).

Evidence was obtained that the apparatus performed as represented by the manufacturer.

The Council on Physical Medicine and Rehabilitation voted to include the Dwyad Portable Oxygen Unit for Aerosol Medication in its list of accepted devices.

Council on Foods and Nutrition

The following products have been accepted as conforming to the Rules of the Council.

JAMES R. WILSON, M.D., *Secretary.*

The National Drug Company, Philadelphia.

PROTINAL—CHOCOLATE FLAVORED consists of high nitrogen casein, cocoa, saccharin, coumarin and powdered sugar.

Analysis (submitted by manufacturer).—Total nitrogen 9.7 per cent, carbohydrate 24.0 per cent, moisture 5.0 per cent, ether extractables 1.0 per cent, sodium 0.03 per cent.

Calories.—3.4 per gram; 102 per ounce.

Vitamins.—No vitamin claims are made, but water-soluble vitamins of milk are contained in the product.

Use.—A whole protein supplement for oral use when extra protein or a concentrated source of protein is required in the diet.

PROTINAL—VANILLA FLAVORED consists of high nitrogen casein, coumarin, vanillin and powdered sugar.

Analysis (submitted by manufacturer).—Total nitrogen 9.7 per cent, carbohydrate 30.0 per cent, moisture 5.0 per cent, ether extractables 0.5 per cent, sodium 0.03 per cent.

Calories.—3.60 per gram; 108 per ounce.

Vitamins.—No vitamin claims are made, but water-soluble vitamins of milk are contained in the product.

Use.—Whole protein supplement for oral use when extra protein or a concentrated source of protein is required in the diet.

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SATURDAY, AUGUST 27, 1949

INDUSTRIAL POLLUTION OF HUMAN ENVIRONMENT

The survival of man depends on his ability to adapt himself to his environment. For thousands of years changes in man's environment resulted from natural causes beyond his control; he tried to mitigate their impact by migrating from regions that had become unfavorable to regions more favorable. Such attempts were not always successful, for various types of primitive man disappeared. About one hundred years have passed since modern man first experimented in modifying his natural environment by the addition of numerous new and often artificial products created by modern industry. Occupational diseases furnish a vivid example of the many and frequently serious new health hazards to which the industrially employed part of mankind has become exposed. The inclusion of some of these agents in consumer goods, such as foodstuffs, cosmetics, medicines, household goods and clothing, and their sometimes indiscriminate use have brought the general population into close contact with the injurious factors in the modern industrial environment. Perhaps the most important and alarming aspect of the recent change in human environment is the increasing and often severe pollution of the air, soil and water with both industrial wastes and regular products of industrial manufacture, such as pesticides and coal and petroleum road tars and asphalts, injurious to human health. The recent disaster at Donora called attention to the problem of air pollution by industrial gases and fumes containing sulfur dioxide, arsenic and fluorine, originating from smelters.

Experiences in the environment of some large copper smelters in the Rocky Mountain area attest that human beings are not the only potential victims of toxic industrial wastes released into the atmosphere. Fumes and gases from petroleum refineries are obnoxious to the people living in their environs; their odors are offensive and even nauseating. Such fumes contribute to the formation of the "smog" encountered in the Los Angeles area and give rise to irritation of the eyes and the respiratory tract. Coke ovens and other industrial plants are a source of excessive production of soot and sulfur dioxide from the burning of coal. Considerable amounts of soot are released into the air during the production of carbon black from natural gas or mineral oil and during the burning of waste oil residues near oil refineries. The potential carcinogenic properties of soot are well established by numerous animal experiments and are supported by the occurrence of cancer of the skin in chimney sweeps. Apparently health hazards of various types exist for the population living in the immediate environment of other industrial establishments through air pollution with wastes.

Prolonged sterilization of the soil has been produced by the deposition of arsenicals from smelter fumes or as insecticides. In a few instances such soil pollution by arsenic-containing industrial wastes has resulted in the contamination of the drinking water supply with toxic amounts of arsenicals. The extensive pollution of rivers and lakes with industrial wastes and urban unprocessed sewage has converted many bodies of public water into unwholesome cesspools, dangerous to any form of life dependent on them as normal environment or for water supply.

People are usually slow in reacting forcefully and effectively to gradually developing conditions injurious to health and survival. Some acute disaster is needed to arouse attention to such environmental health hazards and to force remedial action. The recent Donora disaster served in this role regarding industrial air pollution and brought about the realization, repeatedly voiced at the recent symposium on air pollution held at the Atlantic City meeting of the American Medical Association, that mankind has entered a new world of environmental conditions giving rise to serious health problems. Although acute mass disasters from environmental pollution by industrial wastes are spectacular events because of the number of deaths and diseased persons encountered, such catastrophies occur rather infrequently as the result of unusually massive exposures and are therefore of lesser importance than more widespread and less obvious injuries to health occasioned by the prolonged action of smaller concentrations of the environmental injurious agents on larger population groups. The type and degree of health hazards produced by such exposures is not readily ascertained. Often the symptoms produced are noncharacteristic and may be easily confused with those seen with bacterial infections, nonindustrial allergies or constitutional anomalies. Such insidious and often rather moderate effects on health are of distinct importance at times of more massive exposures, since they lower the resistance of the exposed persons to the higher doses and thereby tend to cause more severe reactions than those that might be elicited in persons not preconditioned by previous contact with low doses of the injurious envi-

ronmental agents. The extent to which such predisposing factors have been active may determine to a large degree the severity of the reactions and of the disaster seen with massive transitory exposures.

PHOTOFLUOROGRAPHY IN GASTRIC CARCINOMA

Recent statistical studies by Dorn,[1] quoted by Roach and his associates,[2] indicate that gastrointestinal cancer develops in approximately 60,000 men and 42,000 women above the age of 40 each year in the United States. Of these more than one half die within one year of the time that the diagnosis is made. Persons who do not survive the disease account for nearly half of the deaths resulting from all types of cancer and 5 per cent of the deaths occurring from any cause. In men, nearly 40 per cent of the tumors arising in the digestive system are gastric in origin. In women, 30 per cent of such lesions lie within the stomach. According to Dorn [1] the average length of life following the recognition of the disease is about one year and eight months regardless of therapy. Although surgical treatment is the method of choice in cancer of the stomach, the average five year survival rate of patients operated on is about 5 per cent even when optimum surgical methods are employed. Pack [3] has found that approximately 50 per cent of patients who have gastric cancer are inoperable when the disease is first diagnosed. Of the remainder almost one half present unresectable lesions. Thus only 25 per cent of persons with gastric cancer have any chance of benefit from surgical intervention. Of these, one third do not survive operation, and of those who do recover over two thirds die from recurrent disease or from other causes within a few years. Thus the average five year survival rate for patients with gastric cancer shrinks to 5 per cent.

If surgical intervention is to achieve better results the recognition of the disease must occur early in its development. Roach and his associates believe that the early diagnosis of gastric cancer is a problem of finding those asymptomatic persons in the general population who have the disease. The roentgenologic method constitutes today the most reliable diagnostic procedure for the examination of the stomach. Gastroscopy and examination of the gastric contents for malignant cells according to the method of Papanicolaou are helpful but not of practical value when large numbers of persons are to be examined. Furthermore, both gastroscopy and aspiration are cumbersome and unpleasant methods so far as the patient is concerned. Roentgenoscopy and roentgenography are slow procedures requiring prolonged services of a highly trained physician. These methods therefore are impractical for mass examination of the stomach. Roach and his co-workers point out that photofluorography, which has been so successful in the early detection of pulmonary lesions, offers the advantages of being inexpensive and rapid in execution and not requiring the services of a fluoroscopist. The disadvantages of the method, such as the excessively large doses of radiation that until now have been necessary to produce satisfactory photofluorograms, have now been overcome by the application of Schmidt optics to photofluorographic camera equipment. Utilizing a camera of the Schmidt type, one can now make photofluorograms of the stomach with a little more exposure than that used in conventional roentgenography. The application of Schmidt optics to photofluorography by the Danish engineer Helm resulted in the development of two cameras, one using 35 mm. perforated film and the other using 70 mm. perforated film. Models of both cameras have been brought to the United States by the Tuberculosis Control Division, United States Public Health Service. Morgan and his associates [4] point out that the principal advantage of cameras of the Schmidt type is their greater speed. Thereby power requirements for the roentgen ray generator are lessened, tube life is extended and radiation dosage to the patient is reduced. The cameras may be used for cineroentgenography and photofluorography of such structures as the abdomen, the gastrointestinal tract and the osseous system.

The reliability of gastric photofluorography is under test by Roach and his co-workers, who have established a pilot survey at the Johns Hopkins Hospital in which all patients above the age of 40 who are admitted to the dispensary outpatient clinic of the hospital during the course of the study will be examined photofluorographically for gastric changes. These authors point out that according to recent statistics one may expect to find only 1 man with gastric cancer in every 700 men studied; in women, the expectant prevalence of the disease is 1 in every 1,200. It is anticipated that within each year of the study between 5,000 and 10,000 patients will be examined and that a minimum of six to twelve gastric carcinomas will pass through the unit. The number of persons whom one may expect to find with carcinoma of the stomach in general population groups of men and women above 40 is approximately 1 in 900. While such an incidence may seem small, in reality it is only slightly less than that of significant pulmonary tuberculosis among the general population, which is 1 in 300 to 500. The survey will cover approximately five years. During this time all patients with abnormal photofluorograms will be restudied with conventional roentgenoscopic technics. Those who present changes suggesting gastric cancer will be operated on. A group

1. Dorn, H. F.: Illness from Cancer in the United States, Pub. Health Rep. **59**: 33, 65 and 97, 1944.
2. Roach, J. F.; Sloan, R. D., and Morgan, R. H.: The Detection of Gastric Carcinoma by Photofluorographic Methods: I. Introduction, Am. J. Roentgenol. **61**: 183 (Feb.) 1949; II. Equipment Design, Am. J. Roentgenol. **61**: 188 (Feb.) 1949.
3. Pack, G. T.: Radical Surgical Treatment of Gastric Cancer, J. Nat. Cancer Inst. **7**: 337 (April) 1947.
4. Morgan, R. H.; Gould, D. M., and VanAllen, W. W.: Two Danish Photofluorographic Cameras of the Original Schmidt Type: III., Am. J. Roentgenol. **59**: 416 (March) 1948.

of approximately 1,000 asymptomatic persons will be examined photofluorographically for gastric changes at intervals of six months. From this study an estimate of the interval at which photofluorographic examinations should be repeated in the general population may be determined.

FATE OF INSULIN IN THE NORMAL AND DIABETIC ORGANISM

Little has been known of the ultimate fate of insulin in the human organism. Obviously, insulin is constantly being eliminated; otherwise cumulative effects manifested by periods of severe hypoglycemia would be observed even in normal subjects. As is well known, however, the blood sugar level is maintained remarkably constant in normal persons. At least two different methods of disposing of insulin appear possible: one by excretion in the urine or possibly feces (via bile) and the other by destruction in the body. The first route, that of excretion, would not appear to be of major importance. The elimination of protein molecules as large as that of insulin (molecular weight 35,000) seldom takes place to any significant extent in the normal kidney and probably not in the bile or feces. Support for this statement is to be found in a recent study [1] in which it was reported that the urine of normal human subjects contains slightly less than 1 unit (0.66 plus or minus 0.04) of insulin per day. Moreover, persons with mild diabetes who were not receiving insulin excreted even less insulin daily and either normal or diabetic subjects given exogenous insulin excreted only minute amounts.

The Ohio investigators also reported the interesting observation that insulin-resistant patients who received large amounts of exogenous insulin appeared to excrete even less insulin in the urine than normal or diabetic subjects. This observation may be significant in elucidating the etiologic aspects of the disease. The foregoing studies thus appear to warrant the conclusion that urinary excretion is not an important pathway for the metabolic disposal of insulin.

Further studies by the Cincinnati group,[2] however, have furnished more definite information on this subject. Aqueous extracts of certain tissues of various animals and man were found to destroy insulin rapidly on incubation. The liver was particularly rich in the substance, and kidney and muscle contained smaller amounts. None was found in brain, whole blood or plasma. As the insulin-inactivating substance was found to be thermolabile and to be inactivated by typical enzyme inhibitors, the investigators believe that the substance is an enzyme and have suggested the name "insulinase." In further studies, fasting produced a definite reduction in the insulinase activity of the liver (rat) just as others have shown to be true of the insulin content of the pancreas. This suggests a relationship between insulin secretion by the pancreas and insulinase secretion by the liver so that a delicate balance between the two may be maintained. The work also suggests that the destruction of insulin by insulinase, particularly in the liver, is the primary means of the disposal of insulin in the animal organism. Further studies on this interesting and important problem may well prove of value in elucidating the etiology of obscure diseases of carbohydrate metabolism such as insulin resistance.

1. Mirsky, I. R.; Podore, C. J.; Wachman, J., and Broh-Kahn, R. H.: J. Clin. Investigation **27**: 515, 1948.
2. Mirsky, I. A., and Broh-Kahn, R. H.: Arch. Biochem. **20**: 1, 1949. Broh-Kahn, R. H., and Mirsky, I. A.: ibid. **20**: 10, 1949.

Current Comment

SENATE REJECTS REORGANIZATION PLAN NO. 1

The United States Senate on August 16 voted 60 to 32 to pass the Fulbright-Taft resolution, S. 147, which rejects the President's Reorganization Plan No. 1. The senators who voted for the resolution were well aware that the health of the public could not be adequately served by a subsidiary section of an elevated Department of Welfare. Apparently the intensive drive made by the present Federal Security Administrator in behalf of nationalized medicine influenced the Senate against the measure which would have made him supreme over government medical services. The Senate, it is reported, resisted heavy executive and political pressure in taking this decisive action.

AUREOMYCIN TREATMENT OF AMEBIASIS

In treating several cases of bacterial infection with aureomycin, McVay [1] and his associates of the University of Tennessee noted alterations in the gross character of the stools. There was a definite reduction in the fecal bacterial count. This local effect led them to test the possible value of aureomycin in the treatment of amebiasis, then prevalent in the Memphis area. Thus far 14 patients with amebiasis have been treated with aureomycin. In a typical case both trophozoite and cystic forms of Endamoeba histolytica were found in the stools of a patient suffering from paraumbilical pain, abdominal fulness and constipation. The patient was given 6.75 grains (439 mg.) of aureomycin orally in divided doses over a period of three days, at the end of which time his stools had become normal. The treatment was continued until the patient had been given a total of 21.75 grains (1,414 mg.) of aureomycin. During treatment the aureomycin blood level reached 8 micrograms per hundred cubic centimeters and all gastrointestinal symptoms disappeared. Results of fourteen subsequent stool examinations over a period of three weeks have been negative. McVay believes that a much larger number of cases with adequate follow-up will be necessary before a final evaluation can be made of the value of aureomycin in the treatment of amebiasis. The high aureomycin blood level observed in his cases leads him to believe that aureomycin therapy will be successful in extraintestinal amebic infections, such as hepatic abscess.

1. McVay, L. V.; Laird, R. L., and Sprunt, D. H.: Science, **109**: 590 (June 10) 1949.

ORGANIZATION SECTION

Washington Letter

(From a Special Correspondent)

Aug. 22, 1949.

Hearings for McCarthy's Department Bill

Shortly after the Senate's defeat of President Truman's plan for a Department of Welfare, an official spokesman for the Senate Expenditures Committee disclosed that public hearings might be scheduled in the near future on S. 2060. This is the bill, sponsored by Senator Joseph R. McCarthy (R. Wis.), which would establish a Department of Health, Education and Security. It is identical to S. 140, on which hearings were held in 1947.

Meantime, in view of the lateness of this session of Congress, it is doubtful whether the Administration will press for enactment of H. R. 782, which would set up a Department of Welfare along lines of the defeated Reorganization Plan No. 1. Capitol observers believe, however, that, if the Senate Expenditures Committee goes through with its plans for hearings on S. 2060, witnesses supporting Administration policies will revive the House bill and urge its enactment over the McCarthy measure.

Plans Advance for Lobbying Investigation

That there will be a congressional investigation of lobbying activities appears to be reasonably certain, although whether it will be conducted jointly by Senate and House or by the House alone is still in doubt. The House has passed a resolution which provides that the inquiry shall be conducted by a select committee of seven representatives appointed by the Speaker. Meantime, however, the Senate has under consideration a separate resolution, favorably reported by its Rules Committee, which calls for the investigation to be held by a committee of five Senators and five representatives who would be appointed by the chairmen of the Senate and House judiciary committees.

School Health Services Bill Ensnarled in Committee

The House Interstate and Foreign Commerce Committee conducted several executive sessions the third week in August in an attempt to agree on changes in the school health services bill (S. 1411), which passed the Senate last April. However, a final draft was not achieved and further meetings were to be held. Under consideration also by the same committee is legislation on federal aid for local public health units and liberalization of the Hill-Burton Hospital Survey and Construction Act. The former has been favorably reported to the Senate, and the hospital bill was passed by the Senate August 9.

Increased Funds for W.H.O. Approved

Awaiting action on the House calendar is H. J. Res. 334, one of the provisions of which is to raise the ceiling on this country's annual contribution to World Health Organization to $3,000,000. At present it is $1,920,000. The resolution was favorably reported to the House in mid-August by the Foreign Affairs Committee. Its sponsor is Representative Thomas E. Morgan (D., Pa.), a physician. Among those who presented arguments in behalf of the larger appropriation was Dr. James R. Miller, Hartford, Conn., who served as a member of the United States delegation to the Second World Health Assembly in Rome last June.

Murray Subcommittee Approves Three Federal Security Agency Bills

The Senate subcommittee on health matters, of which Senator James E. Murray (D., Mont.) is chairman, has approved three bills pertaining to Federal Security Agency administrative policies and forwarded them to the Labor and Public Welfare Committee. They are S.1706, S.2227 and S.2228. In that order, they clarify eligibility of persons living in the Virgin Islands for admittance to St. Elizabeth's Hospital, the federal institution for mental diseases in the District of Columbia; provide for reallocation of venereal disease rapid treatment facilities, and authorize acceptance by Public Health Service hospitals of certain patients committed by state courts.

Efforts Pushed to Rescind Cutback in Veterans Hospitals

Representatives John Rankin (D., Miss.) and Charles E. Bennett (D., Fla.) are the latest to attempt to have Congress direct the Veterans Administration to abandon its plans for a 16,000 bed cutback in its hospital construction program. Both have introduced bills to that effect. On the other side of Capitol Hill, the leader in the campaign for restoration of the original construction program is Senator Claude Pepper (D., Fla.). The second and last volume of testimony presented at public hearings last spring on the cutback is now available and may be obtained from the Senate Labor and Public Welfare Committee.

Coming Medical Meetings

Aero Medical Association, New York, Aug. 29-Sept. 2. Dr. Thomas H. Sutherland, 214 S. State St., Marion, Ohio, Secretary.

American Academy of Ophthalmology and Otolaryngology, Chicago, Oct. 9-14. Dr. W. L. Benedict, 100 First Avenue Bldg., Rochester, Minn., Secretary.

American Association of Obstetricians, Gynecologists and Abdominal Surgeons, Hot Springs, Va., The Homestead, Sept. 8-10. Dr. Leroy A. Calkins, University of Kansas Medical Center, Kansas City 3, Kan., Secretary.

American College of Surgeons, Chicago, Stevens Hotel, Oct. 17-21. Dr. Paul D. Magnuson, 40 E. Erie St., Chicago 11, Secretary.

American Congress of Physical Medicine, Cincinnati, Netherlands Plaza Hotel, Sept. 6-10. Dr. Richard Kovacs, 2 E. 88th St., New York 28, Secretary.

American Hospital Association, Cleveland, Sept. 26-29. Mr. George P. Bugbee, 18 East Division St., Chicago, Executive Secretary.

American Roentgen Ray Society, Cincinnati, Oct. 4-7. Dr. H. Dabney Kerr, University Hospitals, Iowa City, Iowa, Secretary.

American Society of Clinical Pathologists, Chicago, Drake Hotel, Oct. 11-15. Dr. C. G. Culbertson, 740 S. Alabama St., Indianapolis, Secretary.

Colorado State Medical Society, Denver, Shirley-Savoy Hotel, Sept. 20-23. Mr. Harvey T. Sethman, 835 Republic Bldg., Denver, Executive Secretary.

Delaware, Medical Society of, Wilmington, Oct. 13-16. Dr. W. Edwin Bird, 822 North American Bldg., Wilmington, Executive Secretary.

District of Columbia, Medical Society of the, Washington, Hotel Statler, Oct. 17-19. Mr. Theodore Wiprud, 1718 M St. N.W., Washington 6, Secretary.

Gulf Coast Clinical Society, Pensacola, Fla., Oct. 6-7. Dr. Arthur J. Butt Jr., 1101 N. Palafox St., Pensacola, Fla., Secretary.

Indiana State Medical Association, Indianapolis, Sept. 26-29. Mr. Ray E. Smith, 1021 Hume-Mansur Bldg., Indianapolis 4, Executive Secretary.

International Neurological Congress, Paris, France, Sept. 5-10. Dr. Raymond Garcin, 19 rue de Borgogne, Paris, General Secretary.

Kansas City Southwest Clinical Society, Kansas City, Mo., Municipal Auditorium, Oct. 3-6. Dr. W. Merritt Ketchum, 630 Shukert Bldg., Kansas City, Mo., Secretary.

Kentucky State Medical Association, Owensboro, Oct. 6-9. Dr. Bruce Underwood, 620 S. Third St., Louisville 2, Secretary.

Michigan State Medical Society, Grand Rapids, Pantlind Hotel and Civic Auditorium, Sept. 21-23. Dr. L. Fernald Foster, 2020 Olds Tower, Lansing 8, Secretary.

Mississippi Valley Medical Society, St. Louis, Jefferson Hotel, Sept. 28-30. Dr. Harold Swanberg, 209-224 W. C. U. Bldg., Quincy, Ill., Secretary.

Neurological Society of America, Quebec, Canada, Chateau Frontenac, Oct. 17-19. Dr. Edward Schlesinger, 710 W. 168th St., New York, Secretary.

Nevada State Medical Association, Elko, Sept. 29-Oct. 1. Dr. Roland W. Stahr, 118 California Ave., Reno, Secretary.

Northern Minnesota Medical Association, Alexandria, Sept. 9-10. Dr. C. L. Oppegaard, Crookston, Secretary.

Oregon State Medical Society, Eugene, Oct. 12-15. Dr. Werner E. Zeller, Medical-Dental Bldg., Portland 5, Secretary.

Pennsylvania, Medical Society of the State of, Pittsburgh, Hotel William Penn, Sept. 26-29. Dr. W. F. Donaldson, 8104 Jenkins Arcade, Pittsburgh 22, Secretary.

Southern Minnesota Medical Association, Red Wing, Sept. 12. Dr. W. A. Merritt, 102 Second Ave. S.W., Rochester, Secretary.

Southwestern Surgical Congress, Houston, Tex., Shamrock Hotel, Sept. 26-28. Dr. C. R. Rountree, 1200 N. Walker St., Oklahoma City, Secretary.

Utah State Medical Association, Salt Lake City, Sept. 1-3. Dr. Ray T. Woolsey, 42 S. Fifth East St., Salt Lake City 2, Secretary.

Vermont State Medical Society, Burlington, Sept. 8-9. Dr. James P. Hammond, 542 Main St., Bennington, Secretary.

Virginia, Medical Society of, Fort Monroe, Old Point Comfort, Oct. 9-12. Miss Agnes V. Edwards, 1200 E. Clay St., Richmond ,Secretary.

Washington State Medical Association, Seattle, Olympic Hotel, Sept. 11-14. Dr. James W. Haviland, 338 White-Henry-Stuart Bldg., Seattle, Secretary.

Western Orthopedic Association, Santa Barbara, Calif., Biltmore Hotel, Oct. 19-21. Dr. Charles W. Gilhillan, 1680 N. Vine St., Hollywood, Calif., Secretary.

Wisconsin, State Medical Society of, Milwaukee, Hotel Schroeder and Milwaukee Auditorium, Oct. 3-5. Mr. Charles H. Crownhart, 704 E. Gorham St., Madison, Secretary.

World Medical Association, General Assembly, London, Eng., Oct. 10-15. Dr. Louis H. Bauer, 2 E. 103d St., New York City, Secretary General.

Wyoming State Medical Society, Casper, Sept. 12-14. Dr. George H. Phelps, 1606 Capitol Avenue, Cheyenne, Secretary.

GOVERNMENT SERVICES

PUBLIC HEALTH SERVICE

HISTORY OF PLAGUE IN THE U. S.

The communicable disease center at Atlanta, an agency of the U. S. Public Health Service, has published in its bulletin an illustrated history of plague in the United States, along with other articles on the treatment and control of plague. The following chart, including that of Hampton's in *Public Health Reports* of Nov. 16, 1945, shows the number of cases and deaths from plague up through 1947.

YEAR	CASES									TOTALS	
	CALIF.	WASH.	LA.	FLA.	TEX.	OREGON	UTAH	NEV.	IDAHO	CASES	DEATHS
1900	22									22	22
1901	30									30	26
1902	41									41	41
1903	17									17	17
1904	10									10	8
1905-06										0	0
1907	178	3								181	90
1908	8									8	5
1909	3									3	1
1910	3									3	1
1911	4									4	1
1912										0	0
1913	2									2	2
1914	1		30							31	10
1915	1		1							2	1
1916-18										0	0
1919	13		15							28	18
1920	1		7	10	33					51	27
1921	3		3							6	4
1922	2									2	0
1923	1									1	0
1924	41									41	34
1925	1									1	0
1926										0	0
1927	1									1	1
1928	3									3	2
1929-32										0	0
1933	1*									1	1
1934	1					1				2	1
1935										0	0
1936	3						1			4	0
1937	1							1		2	1
1938										0	0
1939							1			1	0
1940									1	1	1
1941	2									2	2
1942	1									1	0
1943	1*									1	1
1944	1									1	0
1945-46**										0	0
TOTAL	397	3	56	10	33	1	2	1	1	504	318

* Case acquired in laboratory

** 1945-1946 data from Public Health Reports for 1945, 1946, and 1947. One case occurred in California in 1947

CASES OF, AND DEATHS FROM, PLAGUE IN THE UNITED STATES (HAMPTON, 1945)

DR. VELDEE RETIRES

Dr. Milton V. Veldee, who had been detailed for twenty years to the National Institute of Health, is now on terminal leave in anticipation of his retirement. His various assignments during the years included service with the American Red Cross in Russia in 1920, medical advisor to the American Consul in Denmark and chief of the Laboratory of Biologics Control since 1931 of the National Institute of Health. His successor at the Institute is Dr. William G. Workman, who also has been with the institute for many years. Dr. Workman was a consultant in preventive medicine to the U. S. Army in Korea and Japan, and an advisor to the military governments in those countries in 1946. At present he is a consultant at the Research and Development Board of the National Military Establishment.

EXAMINATION OF IMMIGRANTS

On July 25, Senior Surgeon Ralph Gregg, assistant chief of the Division of Foreign Quarantine, flew to Europe for a month's inspection of the service offices where applicants for United States immigration visas undergo medical examination. Dr. Gregg was accompanied in Europe by Medical Director Lynne A. Fullerton, who is assigned to the American Embassy in Paris as supervisor of the service's immigration medical work in Europe.

Public Law 774 of 1948 authorizes immigration of 205,000 displaced persons in a two year period. Public Health Service officers serve as medical examiners and report applicants with disease excludable under immigration laws (mental diseases, tuberculosis in any form, contagious diseases and physical defects which may affect ability to earn a living).

Dr. Frank M. Faget is completing thirty-five years' service as medical officer with the Public Health Service and will retire Nov. 1, 1949. Dr. Faget, now on terminal leave, has been medical officer in charge of the Portland (Maine) Marine Hospital for the last two years. Succeeding him in that post is Dr. P. D. Mossman, formerly medical officer in charge at the Seattle Marine Hospital.

DR. KINSEY APPOINTED PHARMACIST DIRECTOR

Dr. Raymond Kinsey has been appointed to the rank of pharmacist director of the Public Health Service. Dr. Kinsey is the first pharmacist officer to be appointed to the director grade in the history of the Public Health Service, according to Surgeon General Leonard A. Scheele. The director grade is the equivalent of the full colonel rank in the Army.

EXAMINATIONS FOR MEDICAL OFFICERS

Examinations will be held October 3-5 for physicians and veterinarians seeking appointment in the Regular Corps of the Public Health Service as medical officers and public health and research veterinarians. Examinations will be held in the following cities: Baltimore, Fort Worth, New Orleans, Memphis, Lexington, Atlanta, Boston, Buffalo, Chicago, Cleveland, Detroit, Los Angeles, San Francisco, Seattle, Denver and Kansas City, Mo., and other cities throughout the country. Applicants have until September 5 to submit their papers. Applications and requests for information should be addressed to the Public Health Service, Federal Security Agency, Washington 25, D. C., Attention: Division of Commissioned Officers.

PERSONAL

Dr. Alexander D. Langmuir has been appointed chief of the Epidemiology Division of the Communicable Disease Center of the Public Health Service. Dr. Langmuir has begun his duties at the Communicable Disease Center in Atlanta, Ga. Before his appointment Dr. Langmuir was associate professor of epidemiology for three years at the Johns Hopkins University School of Hygiene and Public Health.

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Medical News

(Physicians will confer a favor by sending for this department items of news of general interest: such as relate to society activities, new hospitals, education and public health. Programs should be received at least two weeks before the date of meeting.)

COLORADO

State Medical Society Meeting.—The annual session of the Colorado State Medical Society will be held at the Hotel Shirley-Savoy, Denver, September 20-23, under the presidency of Dr. Casper F. Hegner, Denver. Physicians invited to address the scientific sessions include:

Phillips Thygeson, San Jose, Calif., Recent Advances in Our Knowledge of the Etiology and Treatment of Uvietis.
Edward L. Compere, Chicago, Office Management of the More Common Foot Problems of Children.
Herbert A. Wenner, Kansas City, Kan., Recent Advances in the Research of Poliomyelitis.
Charles H. Slocumb, Rochester, Minn., Rheumatoid Arthritis.
Rubin H. Flocks, Iowa City, Some Aspects of the Etiology and Medical Management of Renal Stone.
Perry P. Volpitto, Augusta, Ga., Anesthesia and Analgesia in Obstetric Labor.
Frank H. Lahey, Boston, Management of Lesions of the Stomach, Duodenum and Jejunum.
Mr. William A. Richardson, Rutherford, N. J., First Year of the British National Health Service.

Scientific and technical exhibits will be displayed. A full color television program will be shown through the courtesy of Smith, Kline and French Laboratories of Philadelphia. The annual banquet and dance will be held Friday evening.

CONNECTICUT

Insect Survey.—Field workers are conducting an insect survey in New Haven, Hartford, New Britain, Meriden and Bridgeport this summer under the direction of scientists from Yale University School of Medicine, New Haven. This is a continuation of a program of work started last year. Representatives are spending several days each week in these cities to trap large quantities of "non-biting flies." The insects are used in connection with the continuing studies of viruses being made under the direction of Joseph L. Melnick, Ph.D., associate professor of microbiology at Yale University and Lawrence R. Penner, Ph.D., assistant professor of zoology and entomology at the University of Connecticut, Storrs. This research is sponsored by the National Foundation for Infantile Paralysis, Inc., but it is a part of Yale University's long range program on the relationship between insects and virus diseases now in its eleventh year. The Connecticut insect survey is also part of a similar nationwide program being undertaken in several states this year.

ILLINOIS

Postgraduate Lecture.—The Scientific Service Committee of the Illinois State Medical Society has arranged a lecture for the St. Clair County Medical Society at East St. Louis September 1, when Dr. Joseph H. Kiefer, Chicago, will speak on "Carcinoma of the Prostate." The Sangamon County Medical Society, meeting in Springfield September 1, will hear Dr. Philip Thorek, Chicago, speak on "Portal Hypertension."

Chicago

Grant to Crerar Library for Cancer Collection.—The Illinois Division of the American Cancer Society has given its second annual grant of $1,500 to the John Crerar Library to increase its collection of cancer literature. All volumes in this collection are available to physicians and scientists specializing in the disease. The library now has about 90 per cent of all journals of current importance in the cancer field and through the proceeds of the grant hopes to accomplish close to complete coverage of cancer literature.

Dr. Adams Heads Department of Medicine.—Dr. Wright R. Adams, professor of medicine and associate dean of the Division of Biological Sciences at the University of Chicago, has been appointed chairman of the department of medicine. He will succeed Dr. Lowell T. Coggeshall, who resigned as chairman of the department of medicine July 1 to devote full time to his post as dean of the Division of Biological Sciences and to his research work in internal medicine and tropical diseases. Dr. Adams, a graduate of the University of Illinois College of Medicine, 1929, has been a member of the cardiac department of the University of Chicago Clinics since his appointment to the university in 1930. From 1928 to 1930 he was an intern at St. Luke's Hospital and in 1930 a volunteer in pathology at Cook County Hospital.

Research Grants Awarded.—Five research grants totaling $21,460 have been awarded to the University of Illinois College of Medicine. The Chicago Heart Association granted $10,000 to Dr. Carl C. Pfeiffer in the department of pharmacology for the study of the effects of stress and diet on the regulation of the flow of blood into the kidneys. The National Cancer Institute has renewed a grant of $5,940 for a study involving dyes and cancer of the stomach being conducted by Drs. Andrew C. Ivy and Francis T. Flood. A $2,500 grant has been received from the Roche Foundation in support of a research fellowship involving a continuation of the study of curare-like drugs, under the supervision of Dr. Klaus R. Unna. Abbott Laboratories has made a grant of $2,120 for a study of a synthetic sweetening agent which does not have caloric value, being conducted by Dr. Morton I. Grossman and Miss Charlotte Robertson. Hoffman-LaRoche Inc., has awarded a grant of $900 to subsidize pain tests involving the study of analgesic drugs, under the direction of Dr. Pfeiffer.

Personals.—Dr. James L. Fleming, obstetrician and gynecologist for 46 years, and Dr. George F. Thompson, a surgeon for 50 years and now chairman of the hospital surgical department, were given a testimonial dinner by the attending staff of St. Anne's Hospital June 15.——Dr. Frederick Steigmann, associate director in charge of clinical investigation, Hektoen Institute for Medical Research, has been appointed area consultant in gastroenterology to the Veterans Administration Hospitals in the Middle and Northwestern states.——Municipal Judge Jacob M. Braude has been appointed to succeed Dr. Anton J. Carlson as president and chairman of the Chicago Committee on Alcoholism. Dr. Carlson has been elected honorary president for life.——The distinguished service award of the University of Kansas, Kansas City, was presented to Dr. Warren H. Cole, professor of surgery at the University of Illinois College of Medicine, at recent graduation and alumni exercises. The award is presented annually by the university through its alumni association to graduates for distinguished service. Dr. Cole received the bachelor of science degree from Kansas in 1918. A year ago Dr. Cole served as Senior Scientist Attache for the United States mission to Britain for Science and Technology, which was conducted under the jurisdiction of the Department of State.

IOWA

Stream Pollution Law.—Iowa has passed a new stream and lake pollution law giving the state department of health power to prevent pollution of the state's lakes and streams before it occurs. The law, effective July 4, states among other things that a permit must be issued before the building of a new sewer or a change is made in an existing plant which will empty into a stream or lake. It also requires treatment of domestic sewage and planning for proper disposal of pollutional industrial wastes before they are produced. The original law controlling stream pollution did not authorize the Iowa State Department of Health to prevent new pollution but merely to clean up the pollutional condition after it had occurred.

KANSAS

Kansas Division of Cancer Society Awards.—Six awards will be made for scientific investigation, two each of $500, $300 and $100, by the Kansas Division of the American Cancer Society for work in fields related to growth, cause, diagnosis or treatment of cancer which has been done in the state. Contestants will be divided into two groups, those who have not received a doctorate degree and those who have received a doctorate degree since June 1944. All manuscripts should be submitted in triplicate, the author's name and address appearing on a separate sheet of paper. Further information may be secured from the Kansas Division of the American Cancer Society, 506 New England Building, Topeka, Kansas.

KENTUCKY

County Healthmobile Report.—The Louisville-Jefferson County Board of Health Healthmobile has aided 1,201 county residents during its first six months of operation. According to Dr. David E. Booker, director of clinics, total visits numbered 2,224, of which 324 were infants; 1,456, preschool children; 298, school children; 84 morbidity and 55 prenatal cases.

Personals.—Dr. J. Duffy Hancock, Louisville, has been named Kentucky representative on the newly created council of the Southeastern Surgical Congress.——Dr. Ralph S. Metheny, Louisville, who is chief of medicine at Nichols General Hospital, will become manager August 21 of the new 200 bed Veterans Administration Hospital at Altoona, Pa. Dr. Ronald R. Kaplan, a 1932 graduate of the University of Louisville School of Medicine who is now in charge of the hospital's outpatient department, will be Dr. Metheny's successor.

MARYLAND

State Academy of General Practice Meeting.—The first assembly of the Maryland Academy of General Practice will be held September 29 in Hagerstown. Out of state speakers include:

George M. Lyon, Washington, D. C., Radioactive Isotopes in Clinical Medicine.
Thomas H. McGavack, New York, Diseases of the Thyroid.
John B. Montgomery, Philadelphia, Office Gynecology.
Edward Scott O'Keefe, Lynn, Mass., A High Caloric Diet in the Treatment of Diarrhea in Infancy.
LeRoy H. Sloan, Chicago, Changing Patterns of Disease.

MICHIGAN

State Medical Society Meeting.—The annual session and postgraduate conference of the Michigan State Medical Society will be held in the Pantlind Hotel and Civic Auditorium in Grand Rapids, September 21-23. Physicians addressing the general sessions by invitation include:

Dallas B. Phemister, Chicago, Treatment of Osteomyelitis as Modified by Antibiotic and Chemotherapy.
Arthur R. Colwell, Evanston, Ill., Types of Diabetes Mellitus and Their Management.
John S. Lundy, Rochester, Minn., The Anesthesiologist Is Prepared to Anesthetize the Surgical Patient, to Aid in Differential Diagnosis of Pain Paths and to Resuscitate the Patient.
Earl D. Osborne, Buffalo, Diagnosis and Treatment of Cutaneous Malignancy.
Warren E. Wheeler, Columbus, Ohio, Pulmonary Infections with Histoplasma in Children.
Edwin Davis, Omaha, Pitfalls in Urological Diagnosis.
Joseph L. Baer, Chicago, Prolonged Labor.
Arthur P. Stout, New York, Cancer of the Stomach.
John M. Waugh, Rochester, Minn., Surgical Management of Malignancy of the Ampullary Region.
Frederick H. Falls, Chicago, Early Diagnosis of Carcinoma of the Uterus.
Ralph J. McQuiston, Indianapolis, Deep Infections of the Neck.
Herbert C. Miller Jr., Kansas City, Kan., Effect of Prenatal Factors on Survival of Newborn Infants.
John E. Gordon, Boston, A New Principle in the Control of Communicable Diseases.
Robert M. Zollinger, Columbus, Ohio, Indications for Surgery in Gallbladder Disease.
Edward C. Reifenstein Jr., Syracuse, N. Y., Use of Steroid Hormones in Bone Disease of Aging People.
Ralph O. Rychener, Memphis, Tenn., Glaucoma in General Practice.
William J. Dieckmann, Chicago, Indications and Methods for Terminating Pregnancy in the Last Trimester.
Max Thorek, Chicago, Impending Death Under Anesthesia.
William B. Castle, Boston, Basic Principles in the Treatment of Blood Dyscrasias.
Joseph E. Moore, Baltimore, Recent Advances in the Study of Venereal Diseases.
Harry E. Bacon, Philadelphia, Diagnosis and Treatment of Common Diseases of the Anorectum.
Franklin G. Ebaugh, Denver, Iatrogenicity in Medicine.
Arnold S. Jackson, Madison, Wis., Acute Surgical Abdomen.
Robert L. Jackson, Iowa City, Importance of Breast Feeding.
Ursus V. Portmann, Cleveland, Cancer of the Breast.
Robert E. Gross, Boston, Surgical Treatment for Coarctation of the Aorta.
John P. Peters, New Haven, Conn., Causes and Treatment of Lower Nephron Nephrosis.

Section meetings will be held at noon. An added feature of the meeting will be the postsession "Cancer Day" scheduled for Saturday, September 24. Technical and scientific exhibits will be shown.

MISSOURI

State Board of Medical Examiners.—At a recent meeting of the Missouri State Board of Medical Examiners the following members were selected to serve for one year: Drs. William O. Finney, Chaffee, president; Walter L. Brandon, Poplar Bluff, secretary-treasurer; Edwin C. White, Kansas City; Howard B. Goodrich, Hannibal, and Francis T. H'Doubler, Springfield.

NEW YORK

Personals.—Dr. Harold Buckbee of Dolgeville was named president of the New York State Public Health Officers Organization at its annual meeting.——Dr. William Thalhimer, New York, has been appointed assistant pathologist and medical examiner at the department of laboratories and research of Westchester County located in Grasslands Hospital, Valhalla.

Dr. Evans Appointed to State University.—President Alvin C. Eurich, Ph.D., of the State University of New York on August 15 announced the appointment of Dr. Lester J. Evans as consultant in medical education to the state university. Dr. Evans, medical associate of the Commonwealth Fund, will assume his duties immediately and will continue with the Commonwealth Fund on a part time basis. He will assist in formulating plans for the establishment of the over-all university medical education program. Dr. Evans has been associated with the Commonwealth Fund program for twenty-six years, starting in 1923 as medical director of its child health demonstration activities in Fargo, N. D. Since 1928 he has been a member of the staff at its executive offices in New York City. In his early years with the fund Dr. Evans worked in the fields of preventive medicine, rural hospitalization and rural public health. More recently his primary concerns have been with the supervision of grants for medical education and research. He is a graduate of the School of Medicine of Washington University in St. Louis. He spent two years in graduate pediatric training at the St. Louis Children's Hospital before joining the Commonwealth Fund.

New York City

Offer Hospital Facilities for Study.—Queens General Hospital is opening its wards and clinics to doctors of the county for teaching purposes. It is hoped that physicians who do not have hospital appointments will be the first to avail themselves of this opportunity for study. The plan was inaugurated July 6 at the regular monthly conference of the department of medicine. The schedule included clinics, conferences, seminars, lectures and demonstrations as well as formal war rounds. Dr. Arthur A. Fischl, president of the Medical Society of the County of Queens, stated that the medical society has long advocated such a relationship and has pledged active support of its graduate education committee.

Dr. Most to Head Research in Tropical Medicine.—Dr. Harry Most, associate professor of preventive medicine, has been appointed a full professor of preventive medicine at New York University College of Medicine, a unit of the New York University-Bellevue Medical Center, effective September 1. Dr. Most will continue to be in direct charge of the New York University-Bellevue Medical Center's expanding program of tropical medicine. He will be in charge of a tropical disease diagnostic clinic currently undergoing formation by the New York City Health Department in the Lower East Side District Health Center. Dr. Most, a member of the college faculty for the past ten years, is deputy chief consultant in tropical disease to the Veterans Administration and a member of the National Research Council's Committee on Tropical Disease. He is also consultant in tropical medicine to the surgeon general, U. S. Army, the commissioner of health, New York State, and the marine hospitals of the U. S. Public Health Service.

NORTH CAROLINA

Personal.—Dr. Alfred T. Hamilton has been appointed chief prison surgeon succeeding Dr. Benjamin J. Lawrence, who has held the position for 12 years. Dr. Lawrence is resigning to devote more time to his own practice.

Symposium on Medicine.—The annual symposium of the Duke University School of Medicine, will be held at Durham October 13-15. The general subject will be the "Basis of Disease." Among the guest speakers will be Drs. Stanley E. Bradley, New York City; Daniel E. Clark, Chicago; John H. Dingle, Cleveland; Robert Elman, St. Louis; Paul Klemperer, New York; Joseph L. Lilienthal Jr., Baltimore; Cyril N. H. Long, New Haven, Conn.; William Parsons, Charlottesville, Va.; Hans Selye, Montreal, and Robert W. Wilkins, Boston.

RHODE ISLAND

Dr. Magill Named State's Chief Examiner.—Dr. William H. Magill, Providence, has been appointed to the new post of chief medical examiner of the state. The new system under which twelve county medical examiners will be responsible for examining cases involving violent death or death in suspicious circumstances went into effect July 1. Under the old system there were thirty examiners and an associate examiner. Dr. Magill has been medical examiner in Providence for forty-three years. He personally is charged with performing all autopsies.

TEXAS

Gift to Establish Department of Physical Medicine.—Baylor Hospital, Dallas, recently received a gift of $133,000 from Grady H. Vaughn, Dallas business man and patient at Baylor, to construct and equip a department of physical medicine. The new department will be located on the first floor of the hospital's new Truett Memorial Hospital Building, which is to be constructed.

University Expands Teaching Facilities.—Under provisions of a special appropriation by the legislature of the state of Texas, the University of Texas School of Medicine, Galveston, is admitting 162 students to the first year class this fall. Funds have been provided for necessary expansion of teaching

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facilities and personnel. A new laboratory building, being provided by funds from a special bond issue, will house the departments of bacteriology and parasitology; pharmacology; biochemistry and nutrition, and physiology. It will also provide facilities for an expanded library.

WEST VIRGINIA

State Medical Election.—At the annual meeting of the West Virginia State Medical Association at White Sulphur Springs August 4-6, Dr. Russell B. Bailey of Wheeling was elected president; he will assume duties Jan. 1, 1950. Dr. T. Maxfield Barber, Charleston, was reelected secretary-treasurer for his twenty-third consecutive term. Dr. George F. Evans, Clarksburg, was chosen American Medical Association delegate from West Virginia succeeding Dr. Ivan Fawcett of Wheeling, who has served as one of the two delegates from the state since 1938. The next annual meeting will be held at White Sulphur Springs, July 27-29, 1950.

Personals.—Dr. Charles A. Zeller, medical director of the Governor Bacon Health Center, at Delaware City, Del., was appointed superintendent of Weston State Hospital late last spring. Doctor Zeller succeeded Dr. Joseph L. Knapp, who resigned to become associated with the Beverly Hills Sanitarium in Dallas, Texas. The new superintendent, a graduate of the University of Buffalo School of Medicine, has been active in the field of mental health in Delaware, Pennsylvania, Michigan and Indiana.——Dr. Newman H. Dyer of Charleston, state health commissioner, was elected president of the West Virginia University Alumni Association at the annual meeting in Morgantown during commencement exercises in June.——Dr. Walter E. Vest, Huntington, was elected president of the new West Virginia medical licensing board at its organization meeting held July 7 in Charleston.——Dr. James L. Patterson of Logan has been elected president of the West Virginia Chapter of the Medical College of Virginia Alumni Association, succeeding Dr. L. Rush Lambert of Fairmont.

Survey for Prospective Medical School.—Dr. Alan Gregg, director of medical science for the Rockefeller Foundation, and Dr. Herman G. Weiskotten, dean of Syracuse (N. Y.) University College of Medicine and chairman of the American Medical Association Council on Medical Education and Hospitals, have been asked to conduct separate surveys concerning the advisability of building and maintaining a four year school of medicine and dentistry in West Virginia. The request for the survey was made by the legislative interim committee in consultation with the citizens advisory committee set up by the 1949 legislature for the purpose of studying the whole medical school question. The meeting of the two groups on August 8 followed closely the state medical association's adopted resolution favoring the establishment of the school as a part of West Virginia University. The question of site for the proposed school was not raised by the state association or the two interim groups. The legislative interim committee will meet with the advisory committee when the proposed impartial surveys have been completed. The groups will submit a report to Governor Patteson prior to the next regular session of the legislature in January 1951.

WYOMING

State Medical Meeting.—The Wyoming State Medical Society will hold its annual meeting September 12-14 at the Townsend Hotel in Casper, under the presidency of Dr. George E. Baker, Casper. Guest speakers include:

Claude F. Dixon, Rochester, Minn., Surgery of the Gallbladder.
Daniel R. Higbee, Denver, Case Selection in Treatment of Carcinoma of the Bladder.
L. Martin Hardy, Chicago, Congenital Abnormalities of the Upper Alimentary Tract.
John W. Huffman, Chicago, Postoperative Pulmonary Complications.
Earl E. Barth, Chicago, Roentgen Findings in Common Pulmonary Lesions.
Frederick W. Fitz, Chicago, Bacterial Pneumonia.
Edgar B. Johnwick, Hot Springs, Ark., Observations on Venereal Disease.

The Woman's Auxiliary will meet in conjunction with the state association.

ALASKA

Premarital Examinations.—Beginning June 17 all applicants for marriage licenses in the Territory of Alaska are required to take a physical examination, including a standard serologic test for syphilis within 30 days before the marriage license is issued. In areas not having the services of a licensed physician an affidavit to that effect will be sufficient proof for a U. S. Commissioner to issue a marriage license.

GENERAL

Special Society Election.—The Western Association of Industrial Physicians and Surgeons at its annual meeting in San Francisco chose the following officers: Drs. Rodney R. Beard, San Francisco, president; R. Christopher Leggo, Crockett, Calif., secretary, and John E. Kirkpatrick, San Francisco, treasurer.

New Surgical Society.—The Neurosurgical Society of America was founded June 5, 1948, and incorporated in the State of Illinois the following July. It was formed to stimulate fellowship among young neurosurgeons and to disseminate neurosurgical materials among the group. The requirements for membership must comply with requirements set up by the Board of Neurological Surgery. Officers include Drs. Arthur A. Morris, Washington, D. C., president; Edward R. Schlesinger, New York, secretary, and Irving J. Speigel, Chicago, treasurer. The second annual scientific meeting will be held at the Chateau Frontenac in Quebec October 17-19.

Veterinarians Recommend Use of Pound Dogs for Research.—Resolutions favoring the use of pound animals for medical research and training were passed by three veterinary groups in July. These would apply only to animals that would otherwise have been killed. The same resolution has now been passed by the Conference of Veterinary Physiologists and Pharmacologists, the Public Health Section of the American Veterinary Medical Association and the National Association of Federal Veterinarians. The mutually recommended resolution states in part: "Resolved, that dogs and cats that would otherwise be killed in public pounds be made available under suitable regulations for intelligent humane use in teaching and research laboratories."

Research in Paraplegia.—A program of laboratory and clinical research on paraplegia was announced in July by the National Paraplegia Foundation, which is sponsored by the Paralyzed Veterans of America. The foundation's work is aimed at the problems of civilian paraplegia; headquarters are in the LaSalle Hotel, Chicago. The first and most important step in the program, according to Gilford S. Moss, executive director of the foundation, is the establishment of fellowships to provide uninterrupted research in physiology and bacteriology. Other aims of the foundation are to draw public attention to the plight of the civilian paraplegic and to work toward his rehabilitation. According to Mr. Moss, there are 33 times more paraplegic civilians than paraplegic veterans in the country today.

The Childs Memorial Fund.—The Jane Coffin Childs Memorial Fund for Medical Research during the past year has made grants for support of cancer research projects and fellowship appointments totaling $92,435. Among the largest of the 22 grants are $10,000 to Dr. E. S. Guzman Barron for studies of the metabolism of blood cells and of blood-producing tissues in health and disease; $8,500 to Dr. Samuel C. Harvey, Yale University School of Medicine, New Haven, Conn., for clinical and laboratory studies of cancer; $8,000 to Dr. Eugene L. Opie, Rockefeller Institute for Medical Research, for studies on osmotic and cytologic effects of hepatic tumor-producing diets; $7,500 to Dr. Frances Duran-Reynals, Yale University School of Medicine, for the third year of his present grant for the study of the relation of viruses to tumors.

Southwestern Surgical Congress.—The first annual meeting of the Southwestern Surgical Congress will be held at the Shamrock Hotel, Houston, Texas, September 26-28, under the presidency of Dr. Walter G. Stuck, San Antonio, Texas. Physicians invited to speak include: Robert L. Sanders, Memphis, Tenn.; Benjamin T. Beasley, Atlanta, Ga.; Arthur H. Blakemore, New York; Robert M. Moore, Galveston, Texas; Murray M. Copeland, Washington, D. C.; Keith S. Grimson, Durham, N. C.; Francis C. Grant, Philadelphia; H. Earl Conwell, University, Ala.; J. Duffy Hancock, Louisville, Ky.; Karl A. Meyer, Chicago; Brien T. King, Seattle, and J. Dewey Bisgard, Omaha.

A registration fee of $10 will be charged those other than the founders. The society was formed early in 1949.

Medical Aspects of Crime.—The Medical Correctional Association, an affiliate of the American Prison Association, desires to contact professional personnel interested in or concerned with the medical aspects of crime. The membership in this association is confined to the following groups: (1) physicians employed in penal and correctional institutions or jails; (2) physicians, social welfare workers and special workers engaged in medical research work in penal correctional institutions and jails; (3) physicians, psychiatrists, psychologists, social workers and special workers engaged in medical research work in connection with (*a*) institutions or hospitals for the mentally ill, (*b*) mentally defective persons, (*c*) juvenile delin-

quents, (*d*) defective delinquents, (*e*) outpatient or behavior clinics dealing with any aspect of crime or its prevention, (*f*) criminal, juvenile and domestic relations courts, (*g*) parole, (*h*) probation, (*i*) public and private schools, colleges and universities and (*j*) federal, state, county and municipal public health organizations, and (4) any person who presents satisfactory evidence that he or she is engaged in research or an occupation in which the medical aspects of crime are acknowledged as important features. Officers of the association are Dr. Frank J. Curran, Charlottesville, Va., president, and Dr. Edward C. Rinck, Medical Center for Federal Prisoners, Springfield, Mo., secretary-treasurer. Annual dues of $1 should be sent to the secretary.

Prevalence of Poliomyelitis.—Reports of cases of poliomyelitis for the periods indicated have been received from the National Office of Vital Statistics, U. S. Public Health Service.

Division and State	Week Ended Aug. 13, 1949	Week Ended Aug. 14, 1948	Median Expec.	Jan. 1 to Aug. 13, 1949	Jan. 1 to Aug. 14, 1948	Total * March 19, Aug. 13, 1949	Total * March 20, Aug. 14, 1948
New England States:							
Maine	56	1	1	140	6	140	6
New Hampshire	24	2	..	42	6	42	6
Vermont	3	2	2	17	5	15	4
Massachusetts	139	20	20	354	46	354	43
Rhode Island	7	..	1	21	..	21	..
Connecticut	45	10	10	126	40	123	39
Middle Atlantic States:							
New York	539	59	70	1,401	314	1,381	278
New Jersey	101	40	21	315	175	279	168
Pennsylvania	41	52	45	135	170	125	159
East North Central States:							
Ohio	134	82	25	389	316	383	307
Indiana	126	16	16	496	121	486	111
Illinois	299	60	60	898	230	882	223
Michigan	225	41	41	704	126	677	120
Wisconsin	84	26	8	256	84	242	84
West North Central States:							
Minnesota	142	57	24	592	211	553	203
Iowa	81	36	13	373	234	360	221
Missouri	123	11	5	598†	68	587†	68
North Dakota	58	8	8	187	18	183	18
South Dakota	16	10	1	116	56	94	56
Nebraska	36	34	23	164	185	151	180
Kansas	56	9	9	307	82	281	79
South Atlantic States:							
Delaware	4	11	5	18	77	16	76
Maryland	7	2	2	48	15	39	14
District of Columbia	8	7	7	25	31	24	31
Virginia	26	52	27	108	192‡	98	190‡
West Virginia	39	15	5	157	52	150	47
North Carolina	15	192	7	124†	1,467	97†	1,443
South Carolina	12	31	6	53	184	40	173
Georgia	11	17	8	89†	112	81†	111
Florida	25	13	3	124	145	103	128
East South Central States:							
Kentucky	33	9	8	218	84	210	81
Tennessee	26	27	17	231	136	225	129
Alabama	13	13	8	132	95	119	83
Mississippi	23	11	5	177	63	166	61
West South Central States:							
Arkansas	60	10	2	614	69	603	67
Louisiana	29	4	4	129	61	117	55
Oklahoma	92	28	18	688	170	681	164
Texas	109	90	34	1,323	1,131	1,342	1,110
Mountain States:							
Montana	5	3	2	21	25	20	15
Idaho	44	6	1	203	74	190	47
Wyoming	13	5	1	38	35	38	35
Colorado	50	6	6	160	33	158	31
New Mexico	11	7	2	71	34	70	32
Arizona	18	6	3	62	36	51	35
Utah	..	6	6	68	30	52	27
Nevada	..	..	1	10	2	10	1
Pacific States:							
Washington	38	12	12	181	93	136	75
Oregon	6	9	9	75	49	59	33
California	106	241	40	1,013	1,445	724	1,413
Total	3,158	1,400	.....	13,901†	8,430‡	12,978†	8,080‡
Median, 1944-1948			1,016	5,008		4,745	

* Last two columns show reported incidence since approximate average seasonal low: 21 weeks.

† Corrections (deducted from cumulative totals): Georgia, weeks ended July 23, 1 case; July 30, 1; August 6, 1; North Carolina, week July 23, 1; Missouri, week ended August 6, 1.

‡ Corrections (deducted from cumulative totals): Virginia, July, 6 cases; August, 3 cases. Not allocated to specific weeks.

Roentgen Ray Society Meeting.—The annual meeting of the American Roentgen Ray Society will be held at the Netherland Plaza Hotel, Cincinnati, October 4-7, under the presidency of Dr. Lawrence Reynolds, Detroit. Physicians presenting papers by invitation include:

Robert M. Potter, Chicago, Aid to the Diagnosis of Polypoid Lesions of the Colon.

Charles A. Priviteri, Chamblee, Ga., Gastrointestinal Radiographic Observations of Patients Treated by Vagotomy.

James A. Helmsworth, Johnson McGuire and Benjamin Felson, Columbus, Ohio; Joseph E. Miller, Dallas, Texas; Charles T. Dotter, Israel Steinberg, Cranston W. Holman, New York; and C. Robert Hughes, Robert E. Wise, John R. Hannan, Cleveland, Clinical and Technical Problems in Angiography.

A symposium on thoracic disease has been arranged by the University of Cincinnati College of Medicine with faculty members invited to participate. Other invited speakers on the subject include Drs. John R. McDonald and Oscar T. Clagett, Rochester, Minn.; John A. Evans and Ted R. Smalldon, New York, and Eugene L. Saenger, Cincinnati. A similarly organized symposium has been arranged by Western Reserve University School of Medicine, Cleveland, on the application of radioactive isotopes. In addition to the invited faculty members, invitations have been extended to Dr. Bernard S. Wolf and R. Loevinger, Ph.D., New York; R. J. Kennedy, Ph.D., and W. Snyder, B.S., Washington, D. C.; Drs. Henry Quattler, Urbana, Ill.; Robert H. Coleman, Omaha, Neb., and R. Wayne Rundles, Durham, N. C. A third symposium will be presented by invited faculty members of Ohio State University College of Medicine, Columbus, on Combined Management of Hematologic and Allied Diseases from the Medical and Radiologic Viewpoints. The Caldwell Lecture will be delivered by Dr. Stanley P. Reimann Philadelphia, on "Differentiation of Cells and Tissues." He will receive the medal of the society. The annual banquet will take place Thursday at 7:30 p. m.

LATIN AMERICA

Dr. P. O. Wolff Joins WHO.—Dr. Pablo O. Wolff, Buenos Aires, has been appointed medical officer at the headquarters of the World Health Organization in Geneva, Switzerland, effective July 25.

Institute of Oncology.—On grounds of the Ciudad University, the Liga Dominicana contra el Cancer, Trujillo City, District of Santo Domingo, on May 8 inaugurated its $95,000 Institute of Oncology, built with an initial endowment of $40,000 from Dr. Herbert Pieter, Trujillo City, and completed by public subscription. The hospital has a capacity of 80 beds and is equipped with radium offered by the Hon. President Trumillo Molina.

Child Separation Study.—A five year research study of the effects of separation of children from their mothers is being conducted by psychiatrists of Tavistock Clinic in London. More than 200 children are to be watched at home and in clinics. The research will be conducted at clinics in the North-West Metropolitan Hospital Region and at hostels.

CORRECTION

Coulee Dam Needs Two Doctors.—The U. S. Bureau of Reclamation, which is seeking two doctors for the Coulee Dam area of Eastern Washington will contribute up to $1,500 toward the cost of remodeling an available building into offices as desired by the new tenants, not $15,000 as was stated in THE JOURNAL July 30, page 1108.

Marriages

CLYDE VAUGHAN STANLEY JR., Stanley Town, Va., to Miss Patricia Meighan in Birmingham, Ala., June 30.

JOHN LONG THOMPSON JR., Montgomery, Ala., to Miss Ann Ruth Swift in Birmingham, June 28.

DAVID JOHN STEPHENSON, Denver, to Miss Barbara Loise Waugh in Hanover, N. H., June 25.

GUY PHILLIP SHARPE JR., to Miss Julia Katherine Wright, both of Roanoke, Va., June 25.

SAMUEL B. JOHNSON, New Orleans, to Miss Peggy Boswell at Sanatorium, Miss., June 25.

JAMES DANIEL HARDY, Philadelphia, to Miss Louise Scott Sams at Decatur, Ga., July 1.

JOHN MAY, Bennettsville, S. C., to Miss Betty Brown in Hemingway, June 30.

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Deaths

Robert Sproul Carroll, Asheville, N. C.; born in Cooperstown, Pa., Feb. 18, 1869; Marion-Sims College of Medicine, St. Louis, 1893; Rush Medical College, Chicago, 1897; fellow of the American Psychiatric Association, Association for the Study of Internal Secretions, Association for Research in Nervous and Mental Disease, Southern Society of Philosophy, American Association for the Advancement of Science, American Eugenics Society, American Ethnological Society, American Museum of Natural History and others; a founder and medical director of Dr. Carroll's Sanitarium, changed in 1912 to Highland Hospital, which he presented to Duke University at Durham in 1939 as a therapeutic unit in the department of psychiatry; in 1946 he retired as president and medical director; lecturer in psychiatry at Duke University; author of "The Mastery of Nervousness," 1917; "The Soul in Suffering," 1919; "Old at 40 or Young at 60," 1920; "The Grille Gate," 1922; "Aseptic Meningitis in Combating the Praecox Problem," 1923 and "What Price Alcohol?" 1941; died June 26, aged 80.

Andrew Magee Harvey ✠ Long Beach, Calif.; born in Galesburg, Ill., Jan. 14, 1868; College of Physicians and Surgeons of Chicago, 1893; member of the House of Delegates of the American Medical Association in 1913, 1914 and 1916; emeritus member of the Illinois State Medical Society; member of the American Association of Industrial Physicians and Surgeons; fellow of the American College of Surgeons; served as assistant health officer and acting health officer; formerly practiced in Chicago, where he was chief physician and surgeon for the Crane Company; while residing in La Grange, Ill., he was president of the village board and the board of education; died July 18, aged 60.

William Beverley Mason ✠ Washington, D. C.; born in 1874; Medical College of Virginia, Richmond, 1899; professor emeritus of otorhinolaryngology at George Washington University School of Medicine; specialist certified by the American Board of Otolaryngology; member of the American Laryngological, Rhinological and Otological Society and the American Otological Society; fellow of the American College of Surgeons; affiliated with the Episcopal Eye, Ear and Throat Hospital, where he served on the board, Children's Hospital, Columbia Hospital for Women and Lying-In Asylum, and Central Dispensary and Emergency Hospital; died June 30, aged 74, of coronary arteriosclerosis and duodenal ulcer.

Wilhelm S. Anderson, Northfield, Minn.; University of Minnesota College of Medicine and Surgery, Minneapolis, 1903; specialist certified by the American Board of Internal Medicine; fellow of the American College of Physicians; served on the staffs of the Warren (Minn.) Hospital, Deaconess and St. Michael's hospitals in Grand Forks, N. D., and the U. S. Veterans Hospital in Fort Snelling; died June 26, aged 73, of coronary thrombosis.

Hubert Rogers Arnold ✠ San Francisco; University of California Medical School, San Francisco, 1922; fellow of the American College of Surgeons; affiliated with St. Mary's Hospital; died June 20, aged 55, of cystic myeloma.

Louis Axelrod ✠ Major, M. C., U. S. Army, Chicago; University of Illinois College of Medicine, Chicago, 1941; entered the regular U. S. Army in October 1942; served in Europe during World War II; recently assigned to Fitzsimmons General Hospital in Denver; killed near Idaho Springs, Colo., July 3, aged 32, in a skiing accident.

Charles Edgar Barker ✠ Oklahoma City, Okla.; Denver and Gross College of Medicine, 1907; an Associate Fellow of the American Medical Association; fellow of the American College of Surgeons; one of the founders and formerly vice president Mercy Hospital, where he died June 3, aged 68, of cerebral hemorrhage.

Percy Livingston Barnes, Fort Steilacoom, Wash.; Pulte Medical College, Homeopathic, Cincinnati, 1905; formerly affiliated with Western State Hospital; died in Tacoma recently, aged 68.

Frank Kelsey Belsley, Benton Harbor, Mich.; Washington University School of Medicine, St. Louis, 1935; member of the American Medical Association; past president of the Berrien County Medical Society; affiliated with Mercy Hospital; died May 31, aged 40.

Edward Weston Benham, Mankato, Minn.; University of Minnesota College of Medicine and Surgery, Minneapolis, 1895; died in Compton, Calif., June 19, aged 81, of cerebral arteriosclerosis and generalized arteriosclerosis.

Pauline Bertram, Keokuk, Iowa; College of Physicians and Surgeons, Keokuk, 1890; died May 8, aged 83, of cerebral hemorrhage.

Isabel Mary Geddes Bridges, Orlando, Fla.; Woman's Medical College of the New York Infirmary for Women and Children, New York, 1898; died April 6.

Lionel Botleman Brown ✠ Stratton, Neb.; University of Nebraska College of Medicine, Omaha, 1922; served on the village board and board of health; affiliated with Stewart Hospital; died June 21, aged 53, of cerebral hemorrhage.

Paul Edgar Conrad ✠ Hiawatha, Kan.; University of Nebraska College of Medicine, Omaha, 1924; killed May 20, aged 53, in an airplane crash.

Charles B. Davis, Walker, Mo.; Louisville (Ky.) Medical College, 1893; member of the American Medical Association; past president of the Vernon-Cedar Counties Medical Society; died June 15, aged 81, of cerebral thrombosis.

Rutherford Scott Duemler, Seneca, Mo.; University of Kansas School of Medicine, Kansas City, 1940; member of the American Medical Association; died in Freeman Hospital, Joplin, May 7, aged 38, of calculus of both kidneys.

Samuel Ernest Edmunds, Charleroi, Pa.; Atlantic Medical College, Baltimore, 1910; died June 8, aged 74, of carcinoma of the rectum.

Raymond Clair Fagley, Upper Darby, Pa.; Medico-Chirurgical College of Philadelphia, 1911; member of the American Medical Association, Missouri State Medical Association and the American Psychiatric Association; specialist certified by the American Board of Psychiatry and Neurology, Inc.; served during World Wars I and II; formerly chief medical officer of the regional office, Veterans Administration and senior physician at the Veterans Administration Hospital in Lyons, N. J., died in Kirklyn, May 28, aged 61.

Samuel H. Greene Jr., Washington, D. C.; Columbian University Medical Department, Washington, 1900; member of the American Medical Association; died July 8, aged 75.

Perley Harriman, Kittery, Maine; University of Vermont College of Medicine, Burlington, 1902; member of the American Medical Association and the Massachusetts Medical Society; formerly practiced in Lynn, Mass., where he was affiliated with Union Hospital, where he died June 17, aged 81, of arteriosclerosis and endocarditis.

Frederick Sears Hawes, Russell, Kan.; Gross Medical College, Denver, 1902; served on the Kansas State Board of Registration and Examination; died June 14, aged 76, of carcinoma of the throat.

William Albert Hinckle, Peoria, Ill.; Hahnemann Medical College and Hospital, Chicago, 1903; member of the American Medical Association; past president of the Peoria County Medical Society; served during World War I; died in St. Francis Hospital July 3, aged 73.

Francis Leslie Hoffman, Sonoma, Mich.; University of Michigan Homeopathic Medical School, Ann Arbor, 1893; died May 28, aged 87.

Benjamin Yeager Jaudon ✠ University City, Mo.; Columbia University College of Physicians and Surgeons, New York, 1896; an Associate Fellow of the American Medical Association; at one time medical director of the Missouri State Life Insurance Company in St. Louis; affiliated with Barnes Hospital, St. Louis, where he died July 1, aged 75, of coronary thrombosis.

James M. McCabe, Sun Prairie, Wis.; Milwaukee Medical College, 1908; member of the American Medical Association; died in Columbus May 11, aged 79, of carcinoma of the prostate.

John M. Robinson, Goshen, N. Y.; University of Pennsylvania Department of Medicine, Philadelphia, 1891; specialist certified by the American Board of Ophthalmology; member of the American Academy of Ophthalmology and Otolaryngology and the Minnesota State Medical Association; formerly on the staffs of St. Luke's and St. Mary's hospitals in Duluth, Minn.; died June 24, aged 79, of chronic myocarditis and cerebral hemorrhage.

William C. Russwurm ✠ Helena, Ark.; Louisville (Ky.) Medical College, 1884; Medical Department of Tulane University of Louisiana, New Orleans, 1890; an Associate Fellow of the American Medical Association; past president of the Phillips County Medical Society; died June 9, aged 88, of coronary thrombosis.

Guy Edward Stewart ✠ Fayette, Ala.; Medical College of Alabama, Mobile, 1904; served during World War I; died June 17, aged 68, of coronary thrombosis.

Bureau of Investigation

KOCH'S ADVERTISING TAKES ON A RELIGIOUS FLAVOR

William F. Koch, M.D., of Detroit, has a new angle in the propaganda for his "specific for cancer," frequently mentioned in THE JOURNAL since 1921.[1] He is now using a booklet, "The Birth of a Science," which is sold by mail from Wichita, Kansas, by the Defender Book and Bible House, and published by the Lutheran Research Society, Inc., Detroit.

"The Birth of a Science" describes Koch as "the modern Pasteur." Of him it also says:

"Dr. William Frederick Koch, the man used by a kind and beneficent Providence to give new knowledge to the world for the relief of human suffering, consented to answer questions propounded by the authors. This provided a rich fund of information upon which to draw and enabled them to fill in many details which might have been otherwise lacking."

The booklet attacks organized medicine generally and the editor of THE JOURNAL in particular. Abstracts of testimony of "cures" taken from the proceedings in federal court wherein Koch was prosecuted for violation of the Federal Food, Drug and Cosmetic Act are quoted. Included, also, are the testimonials of osteopaths and a few Doctors of Medicine who have used Koch's injections. (The case mentioned ended in dismissal of the charges in 1948. Two trials, each lasting more than four months, the first in 1943 and the second in 1946, were indecisive. The first jury disagreed, but a member of the second became ill after the case had been heard and referred to the jury. Government attorneys moved for dismissal of the case, rather than try the same set of facts after so long a period had elapsed.) The recital of cures of tuberculosis, cancer, poliomyelitis and "pus infections" is similar to that usually employed by quacks.

The Lutheran Research Society, Inc., of Detroit also publishes a magazine, "The Eleventh Hour." Printed are articles attacking organized medicine, Communism and Jews. The publication hails Koch as a medical martyr and lately sympathizes with the promoters of the now defunct Kaadt Diabetic Institute at South Whitley, Ind.[2] (One of the Kaadt brothers is in a federal prison, the other too ill to begin his term.) At first glance, the "Society" seems to be an organization sponsored by the Lutheran church. The director is one Lawrence F. Reilly, who appears to have been educated for the ministry.

In 1948 Koch advertised his "specific" with a reprint of an excerpt from the *Congressional Record* for June 7, 1948, which was distributed, postage free, throughout the country under the frank of Senator Langer of North Dakota. The senator had obtained unanimous consent to the reading into the *Record* of an article alleged to have appeared in "The Eleventh Hour," reporting successful use of Koch's medication on dairy cattle in Canada. The facts were reported in THE JOURNAL for Aug. 7, 1948, page 1333.

To sell his "specific," Koch no longer has his "Koch Laboratories." Now it is the "Christian Medical Research League" of Detroit. This is a "nonprofit" corporation of Michigan. The articles of incorporation, filed in November 1948, show the purposes of the organization as:

"Research in and development of drugs of a various nature including bio chemical oxidation catalysts, establishment of clinics for research in and mitigation of diseases, and for the training of personnel in the use of bio chemical oxidation catalysts, distribution of drugs and medicines to medical missionaries, manufacture, distribution and sale of drugs and medicines, the conduct of any legitimate business activity that will promote the foregoing or provide funds for the same."

The incorporators are two ministers, the Rev. William T. Watson, D.D., of St. Petersburg, Fla., and the Rev. Sam Swain, D.D., of Akron, Ohio, and a layman, Laurence B. Thatcher of Imlay City, Mich., said to be a dealer in tombstones!

The Rev. Sam Swain is described in the files of the Bureau as:

". . . an ordained minister of the gospel, and his denomination is Evangelical United Brethren . . . He has a bookstore . . . and conducts forums and discussion groups, bringing in outside speakers. His organization is known locally as the National Gospel Center, which is a store-front building on South Broadway in Akron."

The same source reveals that Swain is "on the fringe of quackery in religion and an out-and-out fascist. He is not a member of the Akron Ministerial Association, but is classed by this body as an itinerant evangelistic minister with a low rating of respectability in the community." A fellow minister indicated that he was ashamed that Swain was an ordained minister of his denomination.

The Rev. William T. Watson is said to be the minister of "The Tabernacle" in St. Petersburg, which is not associated with any conference or regular church organization. The facts with respect to his religious training or ordination are not clear, and his sermons are described as being of the "hellfire-and-brimstone" type.

The Defender Book and Bible House is an enterprise of Gerald B. Winrod, one of the defendants in the long-drawn-out trial for subversive activities in Washington, D. C. Government prosecutors proceeded on the basis that Winrod was a Nazi worker; the newspaper stories on his divorce case a few years ago indicated that his wife gave some sensational testimony along the same line. Winrod is described as being a controversial figure and as a preacher with considerable oratorical ability, but he is not known to be connected with any particular religious denomination. Rather, he appears to be in the printing business. He is said to possess an extensive and well equipped printing plant in Wichita, which might account in some manner for his espousal of the Koch propaganda.

Religion and religious beliefs have long been used by quacks and faddists as a smoke-screen for their nefarious activities. Faith healers and cultists have found it profitable to utilize man's craving for mysticism. Some probably have been sincere. The more spectacularly successful, however, have seen the business possibilities and have played the game for all it was worth. One writer,[3] commenting on this tendency in quacks, observed:

"No Quack is a perfect Quack without a pretense of religion. Deprive him of religion and you deprive him of his strongest sales talk. In that respect the Quack differs from the Bootlegger, Poacher and Abortionist. Religion is not regulated by law, until it interferes with the rights of the public . . ."

Again he comments, "Apparently no quack has conscience enough to prevent him from hiding behind religion."

Of the need for physical means to further the acceptance of the healers' doctrines, he wrote:

"Healing by Faith has always its limitations. The patient must have a keen sense of perception—or a keen sense of imagination—to be healed. To overcome any lack of imagination, faith healers usually use some other agency like stump water, boiling a nail in the milk you drink, or carrying a rabbit's foot; on the same principle that physicians sometimes use a 'placebo' or dough pill to impress the patient. A. T. Still's 'placebo' was 'adjusting the spine,' which is just about as effective as trying to warm your feet in the moonlight. Rubbing the back is an old idea, nearly all tribes and races have tried it. Only America has glorified it and made it a system of healing."

Koch, of course, has always had his "Glyoxylide." Now he has the religious approach; he has learned, apparently, that people regard religion with respect and are not apt to question statements made by ministers or priests because of faith in their honesty and sincerity of purpose.

The facts with respect to Lutheran Research Society sponsorship are revealing. Of the Lutheran Research Society, the Division of Public Relations of the National Lutheran Council and the Lutheran Church-Missouri Synod recently released for publication the following statement:

"The Lutheran Research Society of Detroit was disavowed in a joint statement issued here by the National Lutheran Council and the Lutheran Church–Missouri Synod, which represent virtually all the Lutheran groups in America.

"The Society, which has been accused of promoting anti-Semitic propaganda through its periodical, 'The Eleventh Hour,'

1. J. A. M. A. **76:** 466 and 537 (Feb. 12 and 19) 1921; **82:** 2054 (June 21) 1924; **86:** 1469 (May 8) 1926; **88:** 928 (March 19) 1927; **103:** 116 (July 14) 1934; **106:** 929 (March 14) 1936; **107:** 519 and 1405 (Aug. 15 and Oct. 24) 1936; **112:** 1460 (April 15) 1939; **113:** 711 (Aug. 19) 1939; **116:** 2525 (May 31) 1941; **117:** 216 (July 19) 1941; **118:** 734 and 1373 (Feb. 28 and April 18) 1942; **119:** 502 (June 6) 1942; **121:** 691 (Feb. 27) 1943; **122:** 389 (June 5) 1943; **130:** 1040 (April 13) 1946; **137:** 1333 (Aug. 7) 1948.

2. J. A. M. A. **137:** 402 (May 22) 1948.

3. Warner, C. W.: Quacks, Jackson, Miss., The Author, 1930.

and other publications, 'is not sponsored or officially connected with any of the Lutheran church bodies in this country,' the statement said.

"It added that the eight participating bodies of the National Lutheran Council, and the Lutheran Church-Missouri Synod, 'have had no connection with the Lutheran Research Society and have espoused no part of its program.'

"The Lutheran Research Society has, through its publications and otherwise, promoted an alleged cancer remedy and other drugs formerly distributed by Dr. William F. Koch of Detroit, Michigan, which drugs have been questioned by the United States Government, according to counsel. These drugs are currently distributed by an organization known as the Christian Medical Research League. The latter organization is likewise in no way affiliated with any of the Lutheran bodies in America.

"The statement said further that Lawrence F. Reilly, who organized the Lutheran Research Society in 1946, and is its executive director, is not a member of the ministerium of any of the Lutheran bodies in America. All ordained clergymen in the Lutheran Church hold such membership."

The "not-for-profit" activities of the Christian Medical Research League of Detroit are similarly suspect as to their religious character. The Michigan authorities who gave the outfit its charter might well consider the revealing nature of the following item, which appeared on a letterhead of Koch:

"Since Dr. Koch wrote to you in May of 1948, he has turned over the manufacture and distribution of his treatment to the Christian Medical Research League, 14344 East Jefferson Avenue, Detroit, Zone #15. They are selling it only on prescription."

This pseudoreligious promotion in order to get business has resulted in considerable current interest in Koch's treatment. There are Lutheran ministers who have fallen for this line, and some others who may be made of the cloth that produces quacks. For instance, there is one in a small town near Chicago who has urged some of his parishioners suffering from cancer to come to Chicago to be treated by George Franklin Smith, one of Koch's disciples. Smith surrendered his Indiana license to practice medicine in 1948, rather than face charges of gross immorality in the practice of medicine preferred against him by the Indiana State Board of Medical Registration and Examination. He gave these victims, some of whom borrowed the money, the Koch injection. There is indication that one of his patients is still alive, but that case was never proved pathologically to have been of cancer. The pastor has his name on the letterhead of the Christian Medical Research League. He is now said to be urging the epileptic persons of his parish to take a mail-order treatment for epilepsy put out by the Western Medical Corporation of Chicago.

Koch has had thirty years in which to demonstrate the merits of his "specific for cancer." It would seem that by now the world would be beating a path to his door and he could take his place as a great servant of his fellow man by reason of his ability to conquer disease by such an elementary method. Competent medical investigation of his methods has been accorded him. That his claim of discovery of a specific for cancer so long ago is without any foundation of fact is borne out by events which have followed. His treatment is now administered, for the most part, by osteopaths, who may or may not be authorized under the various practice acts to use drugs. He has sold his nostrum to chiropractors, thus aiding the violation of law.[4] These cults have a religious flavor in their background, and so perhaps it is only natural that Koch would follow the line.

On the other hand, a practical problem may have presented itself here. Normal advertising channels are barred to Koch, by reason of the injunction granted against him to the Federal Trade Commission,[5] the government agency having jurisdiction over advertising in the drug field. No longer does he dare to claim therapeutic merit for his product, on the trade package or in the accompanying literature. No doubt he would find himself once more in difficulty with the Federal Food and Drug officials.

The religious approach in the exploitation of a product, which government chemists testified as being undistinguishable from distilled water,[6] as a "specific for cancer" is neither original nor scientific. The "birth of a science" has turned out to be an abortion.

4. J. A. M. A. **106**: 2189 (June 20) 1936.
5. J. A. M. A. **119**: 502 (June 6) 1942.
6. United States vs. William F. Koch (1943).

Medical Examinations and Licensure

COMING EXAMINATIONS AND MEETINGS

NATIONAL BOARD OF MEDICAL EXAMINERS

NATIONAL BOARD OF MEDICAL EXAMINERS: *Parts I and II.* Various Centers. Sept. 12-14. Exec. Sec., Mr. E. S. Elwood, 225 S. 15th St., Philadelphia 2.

EXAMINING BOARDS IN SPECIALTIES

AMERICAN BOARD OF ANESTHESIOLOGY, INC. *Oral.* Denver, Oct. 16-20. Sec., Dr. Curtiss B. Hickcox, 745 Fifth Ave., New York 27.

AMERICAN BOARD OF DERMATOLOGY AND SYPHILOLOGY, INC.: *Written.* Various Centers, Sept. 15. *Oral.* Cincinnati, Oct. 21-23. Sec., Dr. George M. Lewis, 66 East 66th St., New York 21.

AMERICAN BOARD OF INTERNAL MEDICINE: *Written.* Oct. 17. Asst. Sec.-Treas. Dr. W. A. Werrell, 1 Main St., Madison 3, Wis.

AMERICAN BOARD OF NEUROLOGICAL SURGERY: *Oral.* Chicago, June 3. Final date for filing applications is Jan. 1. Sec., Dr. W. J. German, 789 Howard Ave., New Haven.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY, INC. *Part I.* Various Centers. Feb. 3. Final date for filing application is Nov. 5. Sec., Dr. Paul Titus, 1015 Highland Bldg., Pittsburgh.

AMERICAN BOARD OF OPHTHALMOLOGY: St. Louis, Oct. 15-19; Boston, April. Sec., Dr. Edwin B. Dunphy, 56 Ivie Rd., Cape Cottage, Maine.

AMERICAN BOARD OF ORTHOPAEDIC SURGERY. *Part II,* New York City, Feb. 9-10. Address: Sec.-Treas., Dr. Harold A. Sofield, Room 1856, 122 S. Michigan Ave., Chicago.

AMERICAN BOARD OF OTOLARYNGOLOGY: Chicago, Oct. 4-7. Sec., Dr. D. M. Lierle, University Hospitals, Iowa City.

AMERICAN BOARD OF PATHOLOGY: Chicago, Oct. 7-8. Final date for filing application is Sept. 1. Sec., Dr. Robert A. Moore, 507 Euclid Ave., St. Louis.

AMERICAN BOARD OF PEDIATRICS: *Oral.* Cleveland, Sept. 16-18; New York City, Oct. 21-23; Chicago, Dec. 9-11. Sec., Dr. John McK. Mitchell, 6 Cushman Road, Rosemont, Pa.

AMERICAN BOARD OF PLASTIC SURGERY: Examinations are given in June and November of each year in the home town of applicants. Sec.-Treas., Dr. Louis T. Byars, 400 Metropolitan Bldg., St. Louis, Mo.

AMERICAN BOARD OF PREVENTIVE MEDICINE AND PUBLIC HEALTH: *Parts I and II.* New York, Oct. 22-24. Sec., Dr. Ernest L. Stebbins, 615 N. Wolfe St., Baltimore.

AMERICAN BOARD OF PROCTOLOGY: November. Sec., Dr. Louis A. Buie, 102-110 Second Ave., S.W., Rochester, Minn.

AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY, INC. *Special Examination.* Chicago, Oct. 24-25. December, New York City. Final date for filing applications is Sept. 15. Sec., Dr. F. J. Braceland, 102-110 Second Ave., S.W., Rochester, Minn.

AMERICAN BOARD OF RADIOLOGY: *Oral.* Cincinnati, Sept. 28-Oct. 2. Sec., Dr. B. R. Kirklin, 102-110 Second Ave., S.W., Rochester, Minn.

AMERICAN BOARD OF SURGERY: *Written.* Various Centers, October 26. Sec., Dr. J. Stewart Rodman, 225 S. 15th St., Philadelphia.

AMERICAN BOARD OF UROLOGY: *Written.* December. *Oral and Clinical.* Chicago, Feb. 11-15. Final date for receipt of case histories is Sept. 1, 1949. Sec., Dr. Harry Culver, 7935 Sunnyside Road, Minneapolis 18.

BOARDS OF MEDICAL EXAMINERS

ALASKA: * Juneau, Sept. 6. Sec., Dr. W. M. Whitehead, Box 140, Juneau.

ALABAMA: *Examination.* Montgomery, June 27-29. Sec., Dr. D. G. Gill, 519 Dexter Avenue, Montgomery.

ARKANSAS: *Examination.* Little Rock, Nov. 3-4. Sec., Dr. Joe Verser, Harrisburg. *Eclectic.* Little Rock, Nov. 3. Sec., Dr. Clarence H. Young, 1415 Main St., Little Rock.

DISTRICT OF COLUMBIA: * *Examination.* Washington, Nov. 14-15. Sec., Dr. G. C. Ruhland, 4130 E. Municipal Bldg., Washington.

FLORIDA: *Examination.* Jacksonville, Nov. 27-29. Sec., Dr. Frank D. Gray, 12 N. Rosalind Ave., Orlando.

GEORGIA: *Examination.* Atlanta, Oct. 11-12. *Reciprocity.* Atlanta, Oct. 13. Sec., Mr. R. C. Coleman, 111 State Capitol, Atlanta 3.

GUAM: *Endorsement.* Agana, Last Friday of each month. Sec., Capt. C. K. Younglan, Chief of Public Health, Guam, % F.P.O., San Francisco.

ILLINOIS: Chicago, Oct. 4-6. Supt. of Registration, Mr. Fred W. Ruegg, Capitol Bldg., Springfield.

INDIANA: *Examination.* Indianapolis, June. Sec., Dr. Paul R. Tindall, 1138 K. of P. Bldg., Indianapolis.

IOWA: *Examination.* Des Moines, Dec. 5-7. *Reciprocity.* Des Moines, Sept. 5, Oct. 3, Nov. 7, Dec. 5. Sec., Dr. M. A. Royal, 506 Fleming Bldg., Des Moines.

KANSAS: Topeka, Dec. 8-9. Sec., Dr. J. F. Hassig, 905 N. Seventh St., Kansas City.

MARYLAND: *Examination.* Baltimore, Dec. 13-16. Sec., Dr. Lewis P. Gundry, 1215 Cathedral St., Baltimore 1. *Homeopathic. Examination.* Baltimore, Dec. 13-14. Sec., Dr. John A. Evans, 612 West 40th St., Baltimore.

MINNESOTA: * Oct. 18-19. Sec., Dr. Julian F. Du Bois, 230 Lowry Medical Arts Bldg., St. Paul 2.

MISSISSIPPI: *Reciprocity.* Jackson, December. Sec., Dr. Felix J. Underwood, State Board of Health, Jackson 113.

MISSOURI: *Examination.* Jefferson City, October 24-26. *Reciprocity.* Jefferson City, October, 23. Exec. Sec., Mr. John A. Hailey, State Capitol Building, Jefferson City.

MONTANA: Helena, Oct. 3-5. Sec., Dr. Otto G. Klein, First National Bank Bldg., Helena.

NEVADA: Carson City, Nov. 7. Sec., Dr. George H. Ross, 112 N. Curry St., Carson City.

NEW HAMPSHIRE: Concord, Sept. 8-9. Sec., Dr. J. S. Wheeler, 107 State House, Concord.

NEW JERSEY: Oct. 18-21. Sec., Dr. E. S. Hallinger, 28 W. State St., Trenton.

NEW MEXICO: * Santa Fe, Oct. 10-11. Sec., Dr. Charles J. McGoey, Coronado Bldg., Santa Fe.

NEW YORK: *Examination.* New York, Albany, Syracuse and Buffalo, Oct. 4-7. Sec., Dr. Jacob L. Lochner Jr., 23 S. Pearl St., Albany 7.

NORTH CAROLINA: *Endorsement.* Asheville, Oct. 17. Sec., Dr. Ivan Proctor, 226 Hillsboro Street, Raleigh.

OHIO: *Examination.* Columbus, December. *Endorsement.* Oct. 2. Sec., Dr. H. M. Platter, 21 W. Broad St., Columbus.

PUERTO RICO: San Juan, Sept. 6-10. Sec., Dr. Luis Cueto Coll, Box 3717, Santurce.

SOUTH CAROLINA: *Examination.* Columbia, Nov. 8-9. *Reciprocity.* First Monday of every month. Sec., Dr. N. B. Heyward, 1329 Blanding St., Columbia.
TENNESSEE: *Examination.* Memphis, Sept. 28-29. Sec., Dr. H. W. Qualls, 1635 Exchange Bldg., Memphis 3.
VIRGINIA: *Examination.* Richmond, Dec. 2-3. *Reciprocity.* Richmond, Dec. 1. Sec., Dr. K. D. Graves, 631 First St., S.W., Roanoke.
WISCONSIN: * *Examination.* Madison, Jan. 10-12. Sec., Dr. C. A. Dawson, River Falls.
WYOMING: Cheyenne, Oct. 3. Sec., Dr. Franklin D. Yoder, Capitol Bldg., Cheyenne.

* Basic Science Certificate required.

BOARDS OF EXAMINERS IN THE BASIC SCIENCES

ARIZONA: *Examination.* Tucson, Sept. 20. Sec., Mr. Francis A. Roy, Science Hall, University of Arizona, Tucson.
ARKANSAS: *Examination.* Little Rock, Oct. 4. Sec., Mr. L. E. Gebauer, 1002 Donaghey Bldg., Little Rock.
COLORADO: *Examination.* Denver, Sept. 14-15. Sec., Dr. Esther B. Starks, 1459 Ogden St., Denver 3.
DISTRICT OF COLUMBIA: Washington, Oct. 24-25. Sec., Dr. G. C. Ruhland, 4130 E. Municipal Bldg., Washington.
FLORIDA: *Examination.* Gainesville, Nov. 5. Sec., Mr. M. W. Emmel, University of Florida, Gainesville.
MICHIGAN: *Examination.* Detroit and Ann Arbor, Oct. 14-15. Sec., Miss Eloise LeBeau, 101 N. Walnut St., Lansing 15.
MINNESOTA: *Examination.* Minneapolis, Oct. 4-5. Sec., Dr. Raymond N. Bieter, 105 Millard Hall, University of Minnesota, Minneapolis.
NEBRASKA: *Examination.* Omaha, Oct. 4-5. Director, Bureau of Examining Boards, Mr. Oscar F. Humble, Room 1009, State Capitol Bldg., Lincoln 9.
OREGON: Portland, Sept. 10 and Dec. 3. Sec., Mr. Charles D. Byrne, State Board of Higher Education, Eugene.
SOUTH DAKOTA: Vermillion, Dec. 2-3. Sec., Dr. Gregg M. Evans, 310 E. 15th St., Yankton.
WISCONSIN: Milwaukee, Sept. 24 and Dec 3. Sec., Prof. W. H. Barber, Ripon College, Ripon.

Bureau of Legal Medicine and Legislation

MEDICOLEGAL ABSTRACTS

Malpractice: Physician's Failure to Use Sterile Instruments.—This was an action for damages for personal injuries resulting from the alleged negligence of the defendant physician. From a judgment in favor of the physician, the plaintiff appealed to the district court of appeal, second district, division 3, California.

The plaintiff, a man 41 years of age, went to the defendant's office on June 7, 1944, for a cystoscopic examination. After giving the doctor a history he was taken to another room for further tests and examinations preparatory to the cystoscopic examination. The table in the cystoscopic examination room on which the plaintiff was placed was so constructed that the patient could be turned from a prone position to an erect position without being removed therefrom. While on the table the plaintiff could not see and did not know what was being done except what he could feel. A layman, called a technician, prepared him for examination. From a nurse in the next room the technician obtained a tray containing an installator, swab, water tube, two syringes, a peroneal towel and a sheet. He washed the plaintiff's male organ, injected an anesthetic therein and inserted a ¼ inch stopper to hold the anesthetic in place. The defendant, with a cystoscope taken from a tray in another room, then entered the examination room. A cystoscope is an instrument about twice the length of a fountain pen, but smaller in diameter, made of nickel-plated copper, with the end turned up and a hollow shaft through the center. It was lubricated with a nonoily lubricant. The technician removed the stopper, and the defendant introduced the cystoscope into the opening, inserted it through the organ into the bladder and observed the interior of the bladder, which appeared normal in every respect. Catheters were then inserted through the cystoscope into the bladder through both renal pelves and pushed through the ureter to the kidneys. The catheters had been threaded into the cystoscope by someone not named in the evidence. A specimen of urine was collected through the catheters into test tubes, and examination showed no bacteria or pus. A dye solution was injected into each urethral catheter and roentgenograms taken while the plaintiff was in prone and standing positions and while the instruments remained in his body. The catheters were then withdrawn; the solution remaining in the ureter was allowed to trail to the bladder as far as the prostate level, and roentgenograms were taken. All roentgenograms were normal. At the trial, the defendant testified that fever which develops an unusual time after a cystoscopic examination is not the normal reaction therefrom, and he told the plaintiff that if any reaction occurred at all it would occur within two hours. He also told him that the results of the examination were entirely normal, that the blood cell count, hemoglobin, heart, pulse rate and respirations were normal, that his prostate, prostatic secretion and urine were normal, that his prostate was normal in size, shape and consistency, that his bladder was normal, that both his prostate and bladder showed no pathologic condition, that his kidneys and ureters were normal and that he was a textbook picture of perfection.

About twenty-four hours later the plaintiff began feeling odd. He had chills and fever all that night and all the next day. On June 10 he received some medicines from the defendant's office which he understood were sulfonamide drugs, which he started taking in the afternoon, but he continued having chills and fever that day and all the next day, when he was taken to a hospital. The fever and chills persisted until June 14, and he remained in the hospital until June 16. While in the hospital the plaintiff was attended by an assistant of the defendant. The plaintiff asked this assistant what was causing his severe chills and high temperature, and the assistant replied, "That's hard to say. Everyone knows you have an acute infection of the urinary passages, but I can't understand how it got there. But that is why you are being given the sulfa drugs and pyridium. These medicines are for infections of that kind." About a week later, when the plaintiff was able to leave his home for the first time, he went to the defendant's office. He was given a prostatic massage by the defendant's assistant and samples of his urine were taken for tests. After the tests were completed, he asked the assistant as to the results and was told that they showed that he still had a "25 per cent infection." He was given prostatic massages for the next month and on each occasion the defendant's assistant told him that he had an infection present in the urinary tract but that the amount was gradually decreasing, so that at the time of his last visit the test showed only 10 per cent. Sometime after June 23, while the defendant's assistant was giving the plaintiff a prostatic massage, the defendant appeared and the plaintiff said, "Dr. Belt, Dr. Guth just told me that I still have 10 per cent infection present. I didn't have any infection when I came in here in June and I don't see why I should have any now." The defendant replied that 10 per cent was within normal limits. The plaintiff then asked the defendant what had caused the infection in the urinary tract and the severe chills and high temperature, and the defendant replied, "To tell the truth, I don't know." An expert witness called by the plaintiff testified that the twenty-four hours between the time of the examination and the time the plaintiff began to have chills and fever probably was an incubation period for bacteria introduced into the urinary tract in the preparation for or in the making of the examination, that the introduction was evidently due to some defective condition of the instruments or carrying in from the opening of the meatus (the canal in the male organ), the edges of which were not thoroughly cleansed, and that the treatment given in the hospital was for an infection of the urinary tract. As we read the record, said the court, there is no evidence that either the stopper or the cystoscope or the catheters used in the examination were sterilized before insertion into the plaintiff's body. Neither the technician nor the defendant sterilized any one of them or saw any one of them sterilized. They assumed that they had been sterilized. No one testified that he sterilized any one of them. On the other hand, the court acknowledged, there is no direct evidence that they were not sterilized.

The plaintiff argued, in substance, that he had no infection at the time of the examination, which disclosed his genitourinary system to be in a healthy and normal condition; that an infection developed confined to the genitourinary system about twenty-four hours after the defendant's examination; that this infection must have been introduced during the examination by a failure of the defendant or his associates or employees to effect and maintain proper sterilization for the examination, and that an inference of negligence was therefore raised under the doctrine of res ipsa loquitur.

With this evidence before the jury, the trial court at the request of the defendant gave the following instructions: (1) "Negligence on the part of a physician is never to be presumed, and in the absence of expert testimony to the contrary, it is to be presumed that a physician possesses and has exercised the requisite degree of skill and care in examining a patient." (2) "In determining the question of whether the defendant was guilty of negligence as alleged in the complaint you cannot and must not set up a standard of your own but must be governed in that regard solely by the testimony of expert witnesses who have appeared and testified in this case." Under these instructions, said the court of appeals, the jury was not permitted to determine for itself that failure to properly sterilize the instruments inserted into the plaintiff's body or failure to properly sterilize the parts of the body through which the instruments were inserted, or both, was negligence. Failure on the part of a physician in either of these respects, the court continued, is negligence as a matter of common knowledge. There is no law, as applied to the facts of this case, which requires that the jury in determining those questions be governed solely by the testimony of expert witnesses. The practical effect of these instructions was to direct the jury to return a verdict for the defendant. The court of appeals concluded that an instruction is prejudicially erroneous which excludes an issue that is supported by evidence.

Furthermore, the trial court refused to give the following instruction requested by the plaintiff: "When it is common knowledge that an event or a circumstance that has happened to or developed in a patient is of the kind that ordinarily does not occur in the absence of negligence on the part of the physician attending him, the question whether or not the condition was caused by negligence may be decided from the general circumstances as shown by the evidence and in the light of common experience and reason." It is well settled, said the court, that in undertaking a treatment of a patient the practitioner impliedly contracts and represent not only that he possesses the reasonable degree of skill and learning possessed by others of his profession in the locality but that he will use reasonable and ordinary care and skill in the application of such knowledge to accomplish the purpose for which he is employed and that, if injury is caused by a want of such skill or care on his part, he is liable for the consequences which follow. The plaintiff, said the court, does not contend that the defendant did not have the requisite knowledge and skill. His contention is that the defendant was negligent in preparing for and making the examination, that there was no proper sterilization. Where the evidence conflicts, said the court, each party is entitled to have the law given to the jury which is applicable to his theory of the case and the testimony of his witnesses. The evidence in this case, the court of appeals concluded, without the testimony of experts, was sufficient to warrant the jury in finding that the infection was caused by the negligence of the defendant. It was, therefore, prejudicial error to give the two instructions requested by the defendant but to refuse to give the instruction requested by the plaintiff.

[In a dissenting opinion one of the judges said: "The majority opinion essentially holds that the appearance of an infection after surgery warrants an inference that the surgeon was negligent. I cannot agree. I doubt that my associates realize to what strange ends the doctrine they announce would lead. It is trite to say that examination and treatment by the insertion of instruments into or through the natural openings of the body, or through wounds, is a necessary part of the practice of medicine and surgery. It is also elementary that infection is an insidious and dreaded enemy and that great precautions are taken to prevent it. If it appears where a laceration has been repaired or a fracture reduced, or a tonsil removed or a throat or sinus examined or treated, is this a good reason for inferring negligence? If a patient has a sore throat after having his temperature taken, is it to be inferred that the thermometer was unsterile? If so, the practice of medicine and surgery would be a mixed profession and insurance business. A malpractice action would be little more than an order to the defendant to show cause why he should not pay damages. But I find no precedent for the theory on which the majority opinion proceeds. Laymen have never been allowed to say in a malpractice action that there was negligence because, in their opinion, a better result would probably have been reached if there had been no negligence."]

The judgment in favor of the defendant physician was reversed.—*Moore v. Belt, 203 P. (2d) 22 (Calif., 1949).*

Workmen's Compensation Acts: Employees Refusal to Undergo Operation for Repair of Ruptured Intervertebral Disk.—This was a claim for a compensation award for injuries arising out of and in the course of the claimant's employment with the K. Lee Williams Theatres, Inc., as a result of which accident the claimant sustained a fractured intervertebral disk. From the granting of an award of total permanent disability and the claimant's subsequent refusal to undergo a proffered operation for the repair of the fracture, the employer filed an original proceeding for review in the Supreme Court of Oklahoma.

About three months after the original compensation award had been allowed to the claimant, the employer filed a motion with the Industrial Commission asking that the Commission discontinue the payments of temporary total compensation on the ground and for the reason that the claimant's injury could be successfully operated on, that the operation had been tendered to the claimant but that he had refused to undergo it. The claimant replied that the operation offered was a major operation and that he could not legally be required to submit to it. The principal question, said the Supreme Court, is whether the refusal of the claimant to submit to a surgical operation will permit the employer to discontinue compensation payments.

There is much medical testimony in the record, said the Supreme Court. Some four or five physicians and surgeons testified. They all agreed that the claimant's disability is total and likely to be permanent unless an operation is performed, and they all recommended an operation, except one witness who testified that he would not recommend an operation without further hospitalization and while the claimant maintained the mental attitude toward the operation which he had at the time. All the expert witnesses agreed that such operations are 85 to 90 per cent successful but that about 1 per cent of such operations result in death, so that 9 to 14 per cent result either in failure or only in partial success. There was also some evidence to the effect that in some cases the operation resulted in increased disability. The petitioners offered the operation by certain specific doctors and in certain specific hospitals, all of which tenders were refused, and then the petitioners extended the tender to include any hospital or surgeon or any neurologic surgeon or hospital of good reputation comparable to those mentioned in the specific tender, which included the Mayo Clinic and Johns Hopkins.

The employer contended that the claimant's disability should be declared to be temporary rather than permanent because of the claimant's refusal to submit to a surgical operation recommended by the physicians. The petitioners cited a number of cases in which it was held that, where the injury complained of is of such a character as to require skilled and professional needs to determine the cause and extent thereof, the question is one of science and must be proved by the testimony of professional persons. Such is the rule, but in this case all the expert witnesses testified that in their opinion the claimant's injury was a ruptured or fractured intervertebral disk, that his disability was permanent unless relieved by a surgical operation and that the operation indicated was a major operation, successful to the extent of 85 to 90 per cent, with about 1 per cent resulting in death.

The rule appears to be, said the Supreme Court, that "where an employee seeking compensation under the Workmen's Compensation Law of Oklahoma, unreasonably refuses to undergo a minor operation, safe, simple and reasonably certain to effect a cure, the continuing disability results not from the injury but from his own willful act." "Equally true is the rule . . . that the Industrial Commission has no authority to compel an employee to submit to a major operation where there is a risk of life involved in the 'slightest degree.'" In a prior case the Supreme Court of Oklahoma held that the Industrial Commission is without jurisdiction to order an injured employee to submit to an operation involving a risk of life, however slight, merely in order that the pecuniary obligations created by law

in his favor against his employer may be minimized. Under the decisions of this court, the Supreme Court concluded, it cannot therefore be said as a matter of law and in the face of all the testimony of the expert, skilled witnesses in this case that the operation recommended is not a major operation, that there is no risk of life involved in such an operation or that under the record claimant's refusal to submit to an operation was unreasonable. The award in favor of the claimant was therefore affirmed.—*K. Lee Williams Theatres, Inc., v. Mickle, 205 P. (2d) 513 (Oklahoma, 1949).*

Malpractice: Surgeon's Liability for Negligence of Intern. — The plaintiff's father, as guardian of his infant daughter and also in his own right, filed suit to recover damages for injuries to the eyes of his newborn child allegedly caused by the improper application of silver nitrate solution. From a verdict of nonsuit in favor of the defendant physician, the plaintiff appealed to the Supreme Court of Pennsylvania.

The plaintiff and his wife engaged the defendant physician to attend the wife during her pregnancy and to deliver her of an expected child. A cesarian operation was necessary, and when the time arrived the defendant asked that a certain intern, whose name he mentioned, should be informed that "he was to be his assistant and take care of the baby at the time of the delivery." When the child was delivered the defendant turned it over to the intern for the purpose of tying the cord and applying a solution of silver nitrate to the infant's eyes. Silver nitrate is an extremely caustic drug, and proper technic calls for the application of only 1 or 2 drops in each eye followed by prompt irrigation. A subsequent analysis of the silver nitrate used on this occasion revealed that it was a 2.1 [per cent] solution which, it was testified, was not of excessive intensity. The insertion of silver nitrate or other approved prophylactic agent in the eyes of every newborn child is not only a regularly established practice in obstetric cases but is required by the rules and regulations of the Department of Health of the Commonwealth, the purpose being to prevent the disease known as ophthalmia neonatorum. According to the testimony of the special nurse engaged to take care of the wife, the intern filled a syringe and squirted the solution once into the child's left eye and twice into its right eye, putting into the latter "a great many drops"; moreover, he failed to irrigate the eyes during at least the period of five or ten minutes while this nurse remained in the operating room. The result was that the child lost the sight of her right eye completely and the left eye was severely and permanently scarred.

It was the plaintiff's contention that this case should have been submitted to the jury and that the trial court erred in negating the defendant's responsibility as a matter of law. The plaintiff did not charge the defendant personally with any act of negligence either of commission or omission; it was apparently conceded that he was an obstetrician of high repute and that the operation he performed on the wife was entirely satisfactory and not subject to criticism. On the other hand, the plaintiff's testimony made out a prima facie case of negligence against the intern. Therefore, the only legal question involved, said the court, is whether or not the doctrine of respondent superior applies, that is to say, whether or not, for the purpose of and during the course of the operation, which included the immediate care of the infant child, the intern was, in the view of the law, the servant or employee of the defendant physician.

The general principles of law applicable to the situation, said the Supreme Court, are not only clear but so firmly established that there is no need to explore any new and hitherto uncharted pathway in the law. These applicable principles are as follows: 1. In the determination of whether a person is the servant of another, the essential test is whether he is subject to the latter's control or right of control with respect not only to the work to be done but also to the manner of performing it. 2. A servant directed or permitted by his master to perform services for another may become the servant of such other in performing the services; he may become the other's servant as to some acts and not as to others. 3. A person may be the servant of two masters not joint employers at one time as to one act, provided that the service to one does not involve abandonment of the service to the other. 4. When different inferences can fairly be drawn from the evidence as to who is the controlling master of the borrowed employee at the time of the commission of the negligent act, it is for the jury, not the court, to determine the question of agency.

In applying these principles of agency to the present case, said the Supreme Court, it is to be noted at the outset that the defendant's obligation under his contract included not only the wife's prenatal care and the delivery of her child but also the care of the latter until it was turned over to the family physician. The wife testified that the defendant said that he would "perform a cesarian operation and care for the baby for the sum of $200." The defendant himself, when asked whether or not his liability was to continue until the baby was turned over to the family doctor, answered, "I so considered that it was." It may well have been in contemplation that he might need help in taking care of the newborn infant, and, as it subsequently turned out, such help was essential. The necessity of employing assistants is one of the ordinary circumstances of both business and professional life, and it is to regulate just such situations that the law of agency exists. In selecting a person to aid him, the defendant was presumably free to make his own choice; there is nothing in the record to indicate that he was compelled to employ an intern. What he chose to do was to call for and borrow from the hospital an intern who thereby became—or so, at least, a jury might find—his temporary servant or employee for the purpose he was engaged.

The next important fact to be considered, the Supreme Court continued, is that the defendant himself testified that he had complete control of the operating room and of every person within it while the operation was in progress. Asked whether the intern was bound to carry out his orders, his answer was, "That is correct." It can readily be understood, said the court, that, in the course of an operation in the operating room of a hospital and until he leaves that room at the conclusion of the operation, the surgeon is in complete charge of those who are present and assisting him and that such supreme control is indeed essential in view of the high degree of protection to which an anesthetized, unconscious patient is entitled—a protection which the wife could justly claim in this case by reason of her trust and confidence in, and necessary reliance on, the surgeon she has employed to take care of her and her child when born.

If, then, it be true that defendant had supervisory control and the right to give orders to the intern with respect to the very act in the performance of which the latter was negligent, it would follow, according to the classic test of agency hereinbefore stated, that a jury would be justified in concluding that the temporary relationship between the defendant and the intern was that of master and servant and that consequently the defendant was legally liable for the harm caused by the intern's negligence.

It was urged by the defendant that the rule of law in regard to a "borrowed employee" should not apply where the employee is a regular part of the personnel of a public or quasipublic hospital, but such an employee, said the Supreme Court, can be temporarily detached, in whole or in part, from the hospital's general control. As far as the evidence disclosed, it was the defendant, not the hospital, who assigned the intern to the task of inserting the silver nitrate solution into the infant's eyes, and, even if in the performance of that act he may also have been serving the hospital, that fact would not change his legal status with respect to the defendant, since a borrowed employee may, in the performance of a given act, be serving the interests of both his general employer and his temporary master.

In the present case, said the Supreme Court, the court erred in entering a nonsuit. It was for the jury to determine whether the relationship between the defendant and the intern, at the time the child's eyes were injured, was that of master and servant. In the determination of whether the intern was the defendant's servant at that time, the mere fact that he was then in the general employ of the hospital would not prevent the jury from finding that he was also at that same time the servant of the defendant if he was then subject to his orders with respect to the treatment of the child's eyes with the silver nitrate solution. Accordingly the nonsuit in favor of the defendant physician was reversed and the cause remanded for a new trial.—*McConnell v. Williams (two cases), 65 A. (2d) 243 (Pa., 1949).*

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Current Medical Literature

AMERICAN

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Titles marked with an asterisk (*) are abstracted below.

American J. Digestive Diseases, Fort Wayne, Ind.

16:121-160 (April) 1949

Significant Factors in Causation of Biliary Cirrhosis. R. C. Schmitz and R. P. Sinaiko.—p. 121.
Clinical Evaluation of Diverticulosis of Colon. M. Feldman and S. Morrison.—p. 126.
Clinical Aspects of Prolapsed Gastric Mucosa. F. W. Wilson and W. H. Granger.—p. 129.
Observations on Allergy of Respiratory Tract. J. A. Turnbull.—p. 132.
Gastro-Intestinal Food Hypersensitivity: Roentgenographic Demonstration. E. J. Tallant, H. A. O'Neill, F. Urbach and A. H. Price.—p. 140.

American Journal of Diseases of Children, Chicago

77:149-284 (Feb.) 1949

*Influenza Vaccine: Study of Serologic Responses and Incidence of Reactions Following Subcutaneous and Intradermal Inoculation. H. B. Bruyn, G. Meiklejohn and H. Brainerd.—p. 149.
*Essential Xanthomatosis: Fifteen Years' Observation on Case Occurring in Family with Hypercholesteremia. B. Schick and W. M. Sperry —p. 164.
Experimental Peanut Oil Pneumonia in Rabbits. W. G. Gobbel Jr. p.—175.
Retardation of Postnatal Development of Kidneys in Persons with Early Cerebral Lesions. E. C. Roosen-Runge.—p. 185.
Congenital Pseudarthrosis of Tibia and Its Relation to Fragilitas Ossium: Report of Case and Review of Literature. F. Y. Khoo. —p. 201.
Office Management of Allergic Child. J. Glaser.—p. 217.
Present Status of Immunization to and Treatment of Scarlet Fever. P. S. Rhoads.—p. 244.

Influenza Vaccine.—Bruyn and associates inoculated subcutaneously or intradermally a total of 79 children with combined type A and type B influenza virus vaccine. Febrile reactions, with temperatures usually over 101 F., and commonly malaise and headache and occasionally vomiting occurred in more than half the children receiving vaccine subcutaneously. The reactions following intradermal inoculation with either one dose of 0.1 cc. or two doses of 0.1 cc. were approximately half as frequent as those following subcutaneous inoculation and were not accompanied with either high temperatures or constitutional symptoms. The serologic response to vaccination with influenza virus vaccine was comparable in all groups with the results for adults. The two doses of 0.1 cc. given three days apart produced the most satisfactory results. The prevaccination titers to type A influenza in these children were approximately in proportion to age.

Essential Xanthomatosis.—Schick and Sperry recorded in 1936 results of a year's study on a boy who when first seen presented a picture of severe xanthoma tuberosum with pronounced hypercholesteremia. The patient lived thirteen years on a diet free of cholesterol. Despite this regimen, he continued to exhibit pronounced hypercholesteremia and no regression of the disease was noted. The only effects which may be attributed to the cholesterol-free diet were a relatively small decrease in the average cholesterol concentration of the blood serum and the fact that no new lesions appeared. Treatment with thyroid, insulin, lipocaic, vitamin B complex and ultraviolet radiation had no noticeable effect. The patient's mother and father were both hypercholesteremic, and 1 brother maintained an abnormally high concentration of cholesterol in his blood serum. In a second brother the serum cholesterol level frequently exceeded 300 mg. per hundred cubic centimeters but was within the range for supposedly healthy persons. The observations on this family emphasize the heredofamilial nature of essential xanthomatosis and support the concept that inherited hypercholesteremia is the primary disturbance in this disease.

American Journal of Physiology, Baltimore

155:309-490 (Dec.) 1948

Water Ingestion and Excretion in Rats Under Some Chemical Influences. E. F. Adolph.—p. 309.
Partial Nephrectomy and Water Exchanges of Rats. E. F. Adolph and S. L. Parmington.—p. 317.
Myographic Study of Cat's Heart: Effect of Changes in Venous Return and in Peripheral Resistance on Ventricular Contraction. J. R. DiPalma and R. A. Reiss.—p. 327.
Right and Left Heart Failure: Unilateral Rises in Right and Left Auricular Pressure in Hypervolemic Cats Following Near Lethal Doses of Quinidine, Auricular Fibrillation and Epinephrine. R. A. Reiss and J. R. DiPalma.—p. 336.
Heat Lability of Depressor Substance Present in Human Urine: Effects of Section of Vagus Nerves, Ligation of Carotid Artery and of Autonomic Blockade upon Depressor Response. J. M. Little, H. D. Green and J. I. Bumgarner.—p. 345.
Effects of Cold on Infant Rats: Body Temperatures, Oxygen Consumption, Electrocardiograms. Janet Fairfield.—p. 355.
Tolerance to Cold and Anoxia in Infant Rats. E. F. Adolph.—p. 366.
Lethal Limits of Cold Immersion in Adult Rats. E. F. Adolph. —p. 378.
Influence of Temperature on Response of Frogs to X Irradiation. H. M. Patt and Marguerite N. Swift.—p. 388.
Altered Prothrombin Produced by Dicumarol-Treated Rabbits. J. Lein and Patricia S. Lein.—p. 394.
Effect of Thyroxine and Thiouracil on Rate of Phospholipid Turnover in Liver of Rat. Eunice V. Flock, J. L. Bollman and J. Berkson. —p. 402.
Effect of Suprathreshold Changes in Brightness on Form Perception. F. N. Low.—p. 409.
Study of Exchange of Oxygen and Carbon Dioxide in Supraglottic Portion of Respiratory Dead Space. M. Galdston and S. A. Horwitz. —p. 420.

Am. J. Roentgenol. & Rad. Therapy, Springfield, Ill.

61:291-442 (March) 1949

*Clinical and Roentgen Manifestations of Erythroblastosis Fetalis. M. Ritvo, I. A. Shauffer and G. Krosnick.—p. 291.
Primary Hemangioma of Skull: Rare Cranial Tumor; Review of Literature and Report of Case, with Special Reference to Roentgenographic Appearance. B. D. Wyke.—p. 302.
Convolutional Markings in Skull Roentgenograms of Patients with Headache. L. M. Davidoff and H. Gass.—p. 317.
Practical Serialograph for Intracranial Angiography. S. Fineman. —p. 324.
Unresolved Pneumonia: Exclusion Diagnosis. C. L. Hinkel.—p. 335.
Unfused Ossification Centers Associated with Pain in Adult. P. C. Swenson and D. Wilner.—p. 341.
Monostotic Fibrous Dysplasia. G. M. Wyatt and W. S. Randall. —p. 354.
Regional Ileitis (Cicatrizing Enteritis) of Prenatal Origin. J. S. Fetter and W. L. Mills.—p. 366.
*Hodgkin's Disease: Histopathologic and Clinical Classification with Radiotherapeutic Response. P. F. Sahyoun and S. J. Eisenberg. —p. 369.
Roentgen Treatment of Cutaneous Carcinoma Involving Cartilage. L. M. Levi.—p. 380.
Treatment of Radiation Sickness with Adrenal Cortical Hormone (Desoxycorticosterone Acetate): Preliminary Report of 50 Cases. F. Ellinger, B. Roswit and S. M. Glasser.—p. 387.
Depth Dose Measurements for 250 KV. Roentgen Rays. C. B. Braestrup, G. H. Cameron and Patricia McClement.—p. 397.

Roentgen Manifestations of Erythroblastosis Fetalis.—Ritvo and co-workers say that studies carried out at the Boston City Hospital indicate that roentgen studies of the fetus in utero afford valuable data and may permit of a diagnosis of erythroblastosis fetalis in certain instances. The roentgen observations in erythroblastosis fetalis comprise (1) soft tissue changes consisting of generalized edema and enlargement of the liver and spleen, (2) abnormalities of the skeleton, with increased densities in the bones, and (3) evidences of fetal death.

Hodgkin's Disease.—Sahyoun and Eisenberg report 24 cases in which they attempted to correlate the histopathologic aspects with the clinical course and the prognosis. They offer a classification of Hodgkin's disease based on histologic criteria and approximate range of life expectancy. First there is the compactly cellular type, in which the progress is slow and life expectancy is between forty-eight and one hundred and sixty months. The second is the fibrogranulomatous type, which is moderately progressive; the patients with this form can be expected to survive for twenty to sixty months. The third, the loosely cellular type, is rapidly progressive; patients with this form survive only twelve to twenty months. The authors discuss the response to roentgen irradiation and the correlation between the expected course based on histologic study, and the actual course. Nineteen of the 24 cases were followed adequately and in 17 of these 19 the course coincided with the prognosis from histologic study.

Archives of Internal Medicine, Chicago

82:419-518 (Nov.) 1948

Blood Fibrinogen in Myocardial Infarction. L. Meyers.—p. 419.
Tropical Eosinophilic Asthma: Report of Two Cases. I. Fond and P. Ravenna.—p. 422.
Orthostatic Influences on Distribution of Atheromatous Lesions in Cerebral and Other Arteries. S. L. Wilens.—p. 431.
*Syndrome of Short P-R Interval with Abnormal QRS Complexes and Paroxysmal Tachycardia. L. Wolff and P. D. White.—p. 446.
Infectious Diseases: Fourteenth Annual Review of Significant Publications. H. A. Reimann.—p. 468.

Paroxysmal Tachycardia.—Wolff and White report a new series of 41 patients, 28 men and 13 women, 21 between the ages of 13 and 29 and 18 between the ages of 30 and 76, with a syndrome of short P-R interval, wide QRS waves and paroxysmal tachycardia. In a previously reported series of 11 patients with this syndrome 10 were less than 29 years old. Paroxysmal tachycardia occurred in 25 cases of the new series and in 10 of the original 11 cases, making a total of 35 cases with paroxysmal tachycardia in the combined series of 52 cases. Analysis of the 52 cases indicates that this syndrome occurs most commonly in young persons, more often in men than in women and in healthy persons from early childhood to old age. Paroxysmal tachycardia is compatible with good health and strenuous activity and does not predispose to the development of heart disease, although congestive failure rarely may result from prolonged, uncontrolled tachycardia. Except for symptoms due to paroxysmal tachycardia and rare instances of sudden death, none of which occurred in the authors' cases, the abnormal mechanism is asymptomatic and does not affect the prognosis in cases of intercurrent disease, surgical procedures or pregnancy and does not affect longevity. The abnormal electrocardiogram was frequently misinterpreted leading to an erroneous diagnosis of serious heart disease or of paroxysmal ventricular tachycardia in more than one third of the cases. If many electrocardiograms are taken, there is a greater probability of recording normal as well as abnormal ventricular complexes, and if the P-R intervals of the normal and the abnormal ventricular complexes are identical it may be assumed that the abnormal electrocardiogram is due to an accessory conducting pathway with a short conduction interval. Such a pathway would make possible the premature depolarization of part of the ventricular muscle and offers a possible explanation for paroxysmal tachycardia. One of the factors which determines whether or not the QRS complex represents an interference phenomenon or depolarization wholly through the anomalous route is the degree of shortening of the anomalous P-R interval. The critical value depends on many factors but is probably close to 0.08 second. Digitalis may or may not widen the anomalous ventricular complex. In 1 case of auricular fibrillation with anomalous QRS waves, digitalis was ineffective in controlling the ventricular rate.

82:519-640 (Dec.) 1948

*Coccidioidomycosis: Persistence of Residual Pulmonary Lesions. H. E. Bass, A. Schomer and R. Berke.—p. 519.
Antibiotic Therapy for Cutaneous Anthrax: Report of 5 Cases. W. A. Reilly and C. R. Beeson.—p. 529.
Respiration and Circulation in Pulmonary Anoxemia. A. C. Taquini, J. C. Fasciolo, J. R. E. Suarez and H. Chiodi.—p. 534.
Acquired Acute Hemolytic Anemia of Unknown Cause: Report of Case with Fibrinoid Arteritis, Atypical Pneumonia and Lower Nephron Nephrosis. L. J. Rather.—p. 578.
Lutembacher's Syndrome: Report of Case with Unusually Large Atrial Septal Defect. W. K. Purks.—p. 588.
Renal Insufficiency Due to Paroxysmal Cold Hemoglobinuria. R. M. Sussman and H. J. Kayden.—p. 598.
Jarisch-Herxheimer Reaction in Neurosyphilis Treated with Penicillin. M. T. Hoekenga and T. W. Farmer.—p. 611.

Residual Pulmonary Lesion in Coccidioidomycosis.—Bass and associates feel that coccidioidomycosis should no longer be considered a rare disease confined to a small endemic area (the San Joaquin Valley in California). The endemic areas in the United States include Western Texas, Southern New Mexico, Southern and Central Arizona, Southwest Utah and possibly Southern Nevada, and a number of areas in Southern California, in addition to the San Joaquin Valley. The incidence of infection in military personnel who spent part of their military service in the endemic areas was 25 per cent. One's merely driving through an endemic area can result in infection. Any person who presents a pulmonary infiltration in which the diagnosis cannot be readily established should be questioned as to exposure in an endemic area. The authors present observations of 20 veterans of World War II, who had residual lesions of pulmonary coccidioidomycosis. The residual lesions persisted two to five years after the initial infection. The residual lesions were of various types: nodular densities, cavities, mottled infiltrations, fibrosis, pleural effusion and calcification. Skin sensitivity to coccidioidin was observed to diminish with the lapse of time. In cases of cavity formation, no evidence of bronchogenic spread or of seeding to other parts of the lung fields, such as occurs commonly in tuberculosis, was observed. In several of the cases a diagnosis of tuberculosis had been made after the patient's return to civilian life, usually after a routine examination of the chest or preemployment roentgenographic examination. In a number of cases a positive reaction to both the tuberculin and the coccidioidin skin test made diagnosis difficult, but a history of exposure in an endemic area, absence of tubercule bacilli and certain roentgenologic aspects justified a presumptive diagnosis of coccidioidomycosis. Almost all the patients were asymptomatic.

Archives of Neurology and Psychiatry, Chicago

60:425-548 (Nov.) 1948

Cerebral Embolism Following Minor Wounds of Carotid Artery: Report of Autopsy. A. A. Raney.—p. 425.
Retinal, Cerebral and Systemic Arteriosclerosis: Histopathologic Study. B. J. Alpers, F. M. Forster and P. A. Herbut.—p. 440.
Electromyographic Study of Defects of Neuromuscular Transmission in Human Poliomyelitis. R. Hodes.—p. 457.
Reflex Dyskinesia in Children. G. J. Gordon.—p. 474.
Mesantoin® (Methylphenylethyl Hydantoin) in Treatment of Epilepsy in State Hospital. D. B. Ruskin.—p. 484.
Glucose Tolerance in Disturbed Schizophrenic Patients. C. K. Aldrich.—p. 498.
Abscess of Brain Due to Clostridium Perfringens Treated with Penicillin. R. B. Cloward.—p. 504.
Relief of Symptoms Following Encephalography by Combined Premedication and Use of Oxygen. C. J. Kornreich.—p. 512.
Origin of Theory of Conditioned Reflexes: Sechenov; Hughlings Jackson; Pavlov. B. P. Babkin.—p. 520.

Archives of Ophthalmology, Chicago

40:239-370 (Sept.) 1948

Successful Diathermy Treatment of Recurring Retinal Hemorrhage and Retinitis Proliferans: Report of Case. F. H. Verhoeff.—p. 239.
Ocular Changes Associated with Scrub Typhus: Study of 451 Patients. H. G. Scheie.—p. 245.
Nearly One Hundred Years of Ophthalmoscope. M. Sachs.—p. 268.
Cholinesterase in Aqueous of Eye. N. S. Jaffe.—p. 273.
Electrophoretic Patterns of Concentrated Aqueous Humor of Rabbit, Cattle and Horse. L. von Sallmann and D. H. Moore.—p. 279.
Effect of Intramuscular Administration of Morphine, Atropine, Scopolamine and Neostigmine on Human Eye. I. H. Leopold and J. H. Comroe Jr.—p. 285.
Delayed Keratitis Due to Mustard Gas (Dichlorodiethyl Sulfide Burns): Report of 2 Cases. W. S. Atkinson.—p. 291.
Treatment of Ocular Syphilis with Penicillin. C. D. Benton Jr. and A. Heyman.—p. 302.
Diagnosis of Retinoblastoma. A. J. Bedell.—p. 311.
Practical Application of Denervated Iris. N. S. Jaffe.—p. 317.
Clinical Aniseikonia. J. P. Macnie.—p. 326.
Medical Versus Surgical Treatment of Glaucoma. L. Lehrfeld.—p. 332.
Retrolental Fibroplasia: Preliminary Report. A. C. Unsworth.—p. 341.

Bulletin of Johns Hopkins Hospital, Baltimore

84:195-284 (March) 1949

Tissue Culture Studies on Liver Cells of Anaphylactically (Arthus) Sensitized Animals in Presence of Sensitizing Antigen. J. J. Buckley, Sonja M. Buckley and Margaret K. Gey.—p. 195.
Failure of Glucoascorbic Acid in Diet to Produce Scurvy in Mice. R. H. Follis Jr.—p. 204.
Renal Failure in Embolic Glomerulonephritis as Complication of Subacute Bacterial Endocarditis. S. Boyarsky, J. M. Burnett and W. H. Barker.—p. 207.
Studies on Hemolysis of Human Erythrocytes by Homologous Complement in Presence of Tannic Acid. J. L. Peck and L. Thomas.—p. 216.
Simple Volumeter for Measuring Oxygen Consumption of Small Animals. J. L. Lilienthal Jr., K. L. Zierler and B. P. Folk.—p. 238.
Clinical Results of Combined Penicillin and Ice Therapy. R. A. Gilbert, R. A. Call and D. J. Roose.—p. 245.
Circulating Anticoagulants: Technic for Their Detection and Clinical Studies. C. L. Conley, R. C. Hartmann and W. I. Morse II.—p. 255.
Physiologic Studies in Congenital Heart Disease: VIII. Physiologic Findings in 2 Patients with Complete Transposition of Great Vessels. J. A. Campbell, R. J. Bing, J. C. Handelsman and others—p. 269.

California Medicine, San Francisco

70:157-234 (March) 1949

*Experimental and Clinical Use of Polymyxin, Chloromycetin and Aureomycin. P. H. Long, E. B. Schoenbach, Eleanor A. Bliss and others.—p. 157.
Human Psittacosis Cured by Penicillin Therapy. A. F. Goggio.—p. 167.
Tuberculosis in Childhood. L. B. Dickey.—p. 171.
Significance of "Albuminuria" (Proteinuria). D. A. Rytand.—p. 174.
Treatment of Sinusitis in Children. V. Goodhill.—p. 177.
Semiautomatic Rapid Film Changer: Its Use in Radiography and Recording of Rapid Physiologic Movements. C. E. Duisenberg.—p. 182.
Radiation Therapy of Ringworm of Scalp. M. E. Mottram and H. H. Hill.—p. 189.
Report of Outbreak of Ringworm of Scalp Due to M. Audouini. R. O. Gilbert.—p. 194.
Factors Influencing Choice of Hearing Aids. W. T. Duggan.—p. 193.
Early Ambulation in Obstetrics and Gynecology. S. Pillsbury.—p. 202.
Leukocytes in "Virus X" Infection. Carrol S. Small and G. G. Hadley.—p. 205.

Use of Polymyxin, Chloromycetin and Aureomycin.—During the past eighteen months three new antibiotic agents, polymyxin, chloromycetin and aureomycin have been described. Long and co-workers state that polymyxin is an effective antibiotic for the treatment of severe infections produced by Pseudomonas aeruginosa, Hemophilus pertussis, Hemophilus influenzae, Escherichia coli and Aerobacter aerogenes. Its toxicity to date precludes its general use in infections susceptible to its therapeutic effects. Chloromycetin has been demonstrated to be an effective antibiotic agent for the treatment of rickettsial diseases and typhoid fever. It will undoubtedly prove effective in the treatment of other infections produced by certain gram-negative micro-organisms and viral agents. Aureomycin has been shown to be an active antibiotic agent against rickettsial diseases, primary atypical pneumonia, acute brucellosis, pneumococcic, streptococcic and staphylococcic infections, urinary tract infections produced by E. coli, A. aerogenes and Streptococcus fecalis, certain types of infections of the eye and in subacute bacterial endocarditis when the infecting agent is Str. fecalis. Its clinical use in forms of extrapulmonary tuberculosis is in a completely experimental stage. It is not recommended in typhoid fever or in infections due to Ps. aeruginosa or Proteus vulgaris, and it seems to be ineffective in whooping cough. To date, neither chloromycetin nor aureomycin has resulted in significant signs of systemic toxicity.

Canadian Medical Association Journal, Montreal

60:215-328 (March) 1949. **Partial Index**

Studies of Nutrition in Newfoundland Children. Kathleen Scobie, Bertha S. Burke and H. C. Stuart.—p. 233.
Streptomycin in Pulmonary Tuberculosis. J. H. Lee.—p. 241.
Chronic Infection of Female Pelvis. W. F. Abbott.—p. 243.
Role of Surgery in Disease of Thyroid Gland. G. S. Fahrni.—p. 247.
Application of Nerve Block in Diagnosis and Therapy. R. A. Gordon.—p. 251.
Simplified Technic for Determination of Prothrombin Times. P. G. Schwager and L. B. Jaques.—p. 258.
*Kidney Substitutes in Uremia: Use of Kolff's Dialyser in 2 Cases. R. A. Palmer and P. S. Rutherford.—p. 261.
Method of Excision and Primary Closure of Pilonidal Cysts and Sinuses. J. L. Russell.—p. 267.
Azygos Vein in Tomography. D. T. Burke and L. Goldberg.—p. 271.
Respiratory Allergy Due to Fungi. C. H. A. Walton.—p. 272.
Renal Tuberculosis in Children. A. B. Hawthorne and M. Siminovitch.—p. 276.
Final Report on Canadian Red Cross Food Parcels for Prisoners-of-War. F. F. Tisdall, Margaret Wilson, Joan Mitchell and others.—p. 279.
*Preliminary Report on Clinical Trials of Antabuse. R. G. Bell and H. W. Smith.—p. 286.
*BAL in Successful Treatment of Mercury Poisoning from Gray Powder. B. Kanee and I. Stoffman.—p. 292.

Kidney Substitutes in Uremia.—Palmer and Rutherford refer to reports by Kolff, whose dialyzer they used for explanation of the principles involved and of the technic. The dialyzer consists basically of a long cellophane tube wound spirally around a wooden drum which rotates through a large water bath containing essential electrolytes and dextrose. A special hollow axle and rotation coupling at each end permit continuous blood flow during the drum rotation. All parts in contact with the blood are kept sterile. The authors describe their experience with Kolff's dialyzer in 2 patients. In 1 of these the treatment appeared to play a major role in recovery. Kolff's dialyzer is effective in the reduction of uremia and may aid in the immediate recovery of renal function. The authors discuss the indications for the use of kidney substitutes and recommend the early employment of effective kidney substitutes.

Clinical Trials of Antabuse.—According to Bell and Smith antabuse is the Danish trade name for tetraethylthiuramdisulfide. Patients receiving this drug have an abnormal reaction to alcohol in the body. This drug itself has few effects when administered in daily doses of 0.5 Gm. over a period of several months. The symptoms produced by alcohol after administration of antabuse are probably due to interference with the oxidation of alcohol, so that abnormally high levels of acetaldehyde are produced in the body. The report is mainly concerned with the symptoms produced when alcohol is taken after antabuse. Their experiences confirm the results obtained by Jacobsen and associates in Denmark. In accordance with Jacobsen's recommendation that any physician considering the administration of antabuse to his alcoholic patients should first try the effects of antabuse plus alcohol on himself, the first trial was conducted with the authors as subjects. After antabuse was taken (0.5 Gm. daily for four days), alcohol was administered and the effects were observed. The authors experienced the symptoms outlined by Hald and associates, with some additions. The authors describe their observations of alcoholic patients. They gained the impression that the factors concerned in the rate of accumulation of alcohol in the blood are partly responsible for the severity of symptoms seen when a certain quantity of alcohol is administered to a patient who has previously received antabuse. No means of controlling the severity of the reaction has yet been devised. No antabuse should be given until it is certain that the patient is free of alcohol. Serious consequences are to be expected if antabuse is taken while there are appreciable amounts of alcohol in the body. It should not be given to "sober up" an alcoholic person.

BAL in Mercury Poisoning.—Kanee and Stoffman report the case of a 2 year old girl for whom gray powder (mercury with chalk) containing 33 per cent mercury was prescribed in a daily dose of ½ grain (30 mg.) for constipation. At the same time yellow mercuric oxide ointment, 2 per cent, was prescribed once daily for a small meibomian cyst of the right lower eyelid. The child showed signs of mercury poisoning, which failed to respond to treatment until BAL (2,3-dimercaptopropanol) was given. Dosage based on 3 mg. per kilogram of body weight was 0.35 cc. of 10 per cent BAL in oil, every four hours for forty-eight hours. On the third day injections were reduced to four, and thereafter one injection was given daily for four more days. The child was discharged eight days after commencement of BAL therapy, the rash having almost completely faded and the temperature having been normal for three days previously.

Connecticut State Medical Journal, Hartford

13:93-176 (Feb.) 1949

Criteria for Hypertensive Sympathectomy: Preliminary Report of Quantitative Rating Chart. W. B. Scoville and R. L. Post.—p. 95.
"Intraderm Sulfur" in Treatment of Acne Vulgaris. M. J. Strauss and H. Sigel.—p. 100.
Fever in Renal Malignancies. H. R. Newman and H. Levine.—p. 104.
Possible Prevention of Cancer in Chronic Radiodermatitis by Medical Means. G. C. Andrews.—p. 105.
Mucosal Edema in Bronchial Asthma. A. L. Maietta.—p. 109.
*Poisoning Due to Ingestion of Wax Crayons. L. W. Minor.—p. 111.
For Manners Are Not Idle. L. A. Buie.—p. 112.

13:177-286 (March) 1949

Connecticut Program for Hospitalization of the Indigent. W. H. Horton.—p. 179.
Differential Diagnosis of Coronary Artery Disease. H. M. Marvin.—p. 186.
Survey of Accuracy of Certain Chemical Determinations. J. G. Snavely and W. R. C. Golden.—p. 190.
Psychotherapy in Medical Practice. H. M. Fox.—p. 194.
Fluid Balance and Intravenous Therapy. E. Nichols.—p. 197.
Coronary Artery Disease Without Infarction in Youth: Case Report. J. H. Bland.—p. 207.

Poisoning Due to Ingestion of Wax Crayons.—Minor reports a child, aged 2, in whom symptoms of acute poisoning developed following ingestion of orange and yellow crayons. No other source of poisoning could be discovered, and, therefore, this case was assumed to be one of paranitraniline poisoning. The literature contains reports of many such cases, in infants

and as an industrial hazard. According to Jones and Brieger, parared, an organic pigment, is made by combination of diazotized paranitraniline with beta naphthol; they point out that orange and red-orange crayons contain parared whereas red and yellow-red crayons are free from it. The child recovered. It seems important that the child ingested wax crayons on an empty stomach, since it has been proved that animals with full stomachs can tolerate larger doses of paranitraniline than those with empty stomachs.

Gastroenterology, Baltimore

12:177-354 (Feb.) 1949

Vascularization of Human Stomach: Preliminary Note on Shunting Effect of Trauma. A. E. Barclay and F. H. Bentley.—p. 177.
Liver Function in Chronic Alcoholic Patients. I. Incidence of Liver Disease as Indicated by Laboratory Methods and Suggested Screening Procedure. W. L. Voegtlin, W. R. Broz and Marjorie H. Moss. —p. 184.
Gastroscopic Observations in the Army with Special Reference to Gastritis. R. R. Heffner.—p. 199.
*Pain and Hyperamylasemia as Early Signs of Carcinoma of Head of Pancreas and of Ampulla of Vater. C. A. Ross and F. W. Klinge. —p. 204.
Description of a New Gastroscope. D. T. Chamberlin.—p. 209.
Studies on Nausea: Effects of Ipecac and Other Emetics on Human Stomach and Duodenum. S. Wolf.—p. 212.
*Use of Tetraethylammonium Chloride in Treatment of Patients with Peptic Ulcer. D. Cayer, J. M. Little and J. Yeagley.—p. 219.
Argentaffine Tumors of Gastro-Intestinal Tract: Report of Eleven Cases. C. H. Brown, R. P. Bissonnette and H. H. Steele.—p. 225.
*Benign Paroxysmal Peritonitis—Second Series. S. Siegal.—p. 234.
Simple Non-Irritating Tube for Feeding Purposes. W. W. L. Glenn. —p. 248.
Influence of Sugar upon Olfactory Acuity and upon Sensation Complex of Appetite and Satiety. F. R. Goetzl, Margaret Goldschmidt, Priscilla Wheeler and Freya Stone.—p. 252.
Postprandial Symptoms Following Subtotal Gastrectomy for Peptic Ulcer and Their Relationship to Glucose Tolerance Curve. S. E. Schechter and H. Necheles.—p. 258.
Effects of Tetraethylammonium Chloride on Human Gastrointestinal Tract. Rosalie B. Neligh, J. F. Holt, R. H. Lyons and others. —p. 275.

Pain and Hyperamylasemia in Carcinoma.—Ross and Klinge report 30 patients, 23 men and 7 women between the ages of 31 and 83, with carcinoma of the head of the pancreas and 10 patients, 8 men and 2 women between the ages of 24 and 68, with carcinoma of the ampula of Vater. Twenty-five of the first group had pain, most often located in the epigastrium or right upper quadrant. Only 2 of the second group had any pain, and in both of these there was coincident gallbladder disease. Even in these 2 cases of pain in ampullary carcinoma, pain did not precede the jaundice; whereas, with carcinoma of the head of the pancreas, pain consistently preceded jaundice. The average duration of symptoms was 4.6 months in carcinoma of the pancreas and 2.8 months in ampullary carcinoma. The average duration of jaundice was essentially the same for the two groups. The serum amylase was elevated in one third of the cases of carcinoma of the head of the pancreas and in all but 1 case of ampullary carcinoma. A correlation of the serum amylase level with the duration of symptoms is demonstrated, the amylase levels being elevated early in the course of the disease. The determination of serum amylase in patients with unexplained abdominal pain may lead to earlier diagnosis of carcinoma of the pancreas and of the ampulla of Vater.

Tetraethylammonium Chloride in Peptic Ulcer.—Cayer and co-workers treated 12 patients with active duodenal ulcer who were having pain while being treated with diet, bed rest, sedation and antispasmodics, with tetraethylammonium chloride given intramuscularly three times daily between meals and at bedtime. The intital dose of 300 mg. was increased by 100 mg. per dose until the patient was receiving 600 mg. at each injection. Pain was relieved in fifteen to twenty minutes, and when tetraethylammonium chloride therapy was continued between feedings pain could usually be prevented. Ulcer symptoms can usually be controlled during the day by dietary and other less experimental means. The most satisfactory results in the authors' cases were obtained in patients with persistent night pain; the alleviation of pain allowed the patient at least six hours of undisturbed rest. Unpleasant side effects from the drug were minimal. No alteration of gastrointestinal motility was noted in roentgenologic examination, but there appeared to be some diminution in the secretion of free acid. The relief of pain provided by the drug may be due to an alteration in the response of the circulation of the gastric mucosa.

Benign Paroxysmal Peritonitis.—Siegal reports, in addition to the 5 cases of benign paroxysmal peritonitis described by him in 1945, 6 new cases in 3 men between the ages of 29 and 32 and in 3 women between the ages of 28 and 63. This disease begins early in life and continues for many years. It is characterized by recurrent paroxysms of abdominal pain with signs of peritoneal irritation. Fever is present, ranging from 100 F. (37.8 C.) to 105 F. (41.5 C.). Leukocytosis and polymorphonucleosis are frequent in the attack. Chest pain, worse on inspiration, is a common accompaniment. Intervals between episodes, most often one to four weeks, may involve months or even years. These patients remain otherwise well. The practical difficulties of diagnosis must be emphasized particularly as to differentiation from an acute surgical abdominal condition, such as that due to appendicitis. Three patients were operated on during an acute attack. Hyperemia or edema of the peritoneum, with or without serous or serofibrinous exudate, comprise the operative observations. Results of exploration after an interval of several years have been normal. The occurrence of this disease in 5 male members of a single family indicates a definite familial tendency and possibly a genetic factor. All published cases which appear to belong to this clinical category have been either in Jewish or Armenian patients. Benign paroxysmal peritonitis possesses many of the clinical attributes of an allergic disorder. Of 11 patients, 2 had atopic conditions and 4 more had a definite family history of allergy, but causative food allergens were not demonstrated in any of 5 cases completely studied from this point of view. Neither epinephrine nor the antihistamine drugs control the acute attack.

Journal of Infectious Diseases, Chicago

84:111-220 (March-April) 1949

Immunological Studies in Mice Infected with Larvae of Ascaris Lumbricoides: I. Criteria of Immunity and Immunizing Effect of Isolated Worm Tissues. J. F. A. Sprent and H. H. Chen.—p. 111.
Extracellular Development of Agents of Psittacosis-Lymphogranuloma Group (Chlamydozoaceae). E. Weiss.—p. 125.
Measurement of Aerobic Respiration in Leptospira Icterohaemorrhagiae. P. B. Marshall.—p. 150.
Pathogenesis and Pathology of Experimental Air-Borne Influenza Virus A infections in Mice. C. G. Loosli.—p. 153.
Cellular Reactions in Haemobartonella Infected Rats with Anemia Produced by Anti-Blood Immune Serum. T. B. Thomas, C. M. Pomerat and E. H. Frieden.—p. 169.
Role of Spleen and Lymphoid-Macrophage System in Quinine Treatment of Gallinaceum Malaria: III. Action of Quinine and of Immunity Parasite. W. H. Taliaferro and Lucy Graves Taliaferro.—p. 187.

Journal of Lab. and Clinical Medicine, St. Louis

34:297-438 (March) 1949

Studies with Colloids Containing Radioisotopes of Yttrium, Zirconium, Columbium, and Lanthanum. J. W. Gofman.—p. 297.
Experimental Study of Effect of Zirconium and Sodium Citrate Treatment on Metabolism of Plutonium and Radioyttrium. J. Schubert.—p. 313.
Significance of Amino Acid Composition of Proteins Excreted by Nephrotic Child. A. A. Albanese, Virginia I. Davis, Emilie M. Smetak and Marilyn Lein.—p. 326.
Nutritional Status and Infection Response: II. Electrophoretic, Circulating Plasma Protein, Hematologic, Hematopoietic, and Pathologic Responses to Mycobacterium Tuberculosis (H37RV) Infection in Protein-deficient Rat. J. Metcoff, Dorothy Darling, Doris Wilson and others.—p. 335.
Resistance of Tubercle Bacillus to Streptomycin. B. Blattberg and Helen Ehrhorn.—p. 358.
Blood and Cerebrospinal Fluid Concentrations of Aureomycin after Oral and Intramuscular Administration. M. H. Lepper, H. F. Dowling, R. L. Brickhouse and E. R. Caldwell Jr.—p. 366.
Action of Thephorin upon Histamine-Induced Gastric Secretion in Dogs and on Gastric Ulcer Formation in Rats. G. Lehmann and P. L. Stefko.—p. 372.
Effects of Intravenously Administered Histamine on Peripheral Circulation in Man. K. G. Wakim, G. A. Peters, Jean C. Terrier and B. T. Horton.—p. 380.
Photoelectric Determination of Arterial Oxygen Saturation in Man. E. H. Wood and J. E. Geraci.—p. 387.
Isolation of Herpes Simplex Virus on Chorioallantoic Membrane. L. L. Coriell, H. Blank and T. F. McN. Scott.—p. 402.
Therapeutic Effect of Tryptophane in Human Pellagra. R. W. Vilter, J. F. Mueller and W. B. Bean.—p. 409.
Study of Histochemical Iron Using Tracer Methods. K. M. Endicott, T. Gillman, G. Brecher and others.—p. 414.

Journal of Nat. Cancer Inst., Washington, D. C.

9:261-378 (Feb.) 1949

Distribution Studies in Mice Following Intravenous Injection of Diethyl Beta-Iodoethyl Amine Hydrochloride Prepared with Radioactive Iodine. A. M. Seligman, A. M. Rutenburg and O. M. Friedman.—p. 261.
Fibroids in Guinea Pig (Family 13) After Partial Castration. E. M. Nadel.—p. 271.
*Masculinizing Ovarian Tumor of Adrenal Type. E. J. Mortell.—p. 277.
Some Observations on Normal and Pathologic Anatomy of Kidney of Mouse. Thelma B. Dunn.—p. 285.
Aldolase in Serum and Tissues of Tumor-Bearing Animals. J. A. Sibley and A. L. Lehninger.—p. 303.
Cytologic Studies on Nature of Cytoplasmic Particulates in Cloudman S91 Mouse Melanoma, Derived Algire S91A Partially Amelanotic Melanoma, and Harding-Passey Mouse Melanoma. M. W. Woods, H. G. duBuy, D. Burk and Marie L. Hesselbach.—p. 311.
Enzymatic Activities of Isolated Amelanotic and Melanotic Granules of Mouse Melanomas and Suggested Relationship to Mitochondria. H. G. duBuy, M. W. Woods, Dean Burk and Mary D. Lackey.—p. 325.
Physicochemical Studies of Reversible and Irreversible Complexes of Cobalt, Histidine, and Molecular Oxygen. J. Z. Hearon, D. Burk and A. L. Schade.—p. 337.

Masculinizing Ovarian Tumor of Adrenal Type.—Mortell reports a woman, aged 46, who had begun to show signs of masculinization at the age of 40. Generalized hirsutism, baldness, masculine contours and enlargement of the clitoris gradually developed. Preoperative urinary excretion of 17-ketosteroids was 8 mg. in twenty-four hours. Bilateral oophorectomy and supravaginal hysterectomy were performed. Both ovaries were somewhat larger than normal, and the right ovary was larger than the left. Section of the right ovary showed the smooth circular outline of a solid tumor, about 18 mm. in diameter. The tumor had no capsule, but there was no sign of infiltrating growth. Examination of sections of the tumor led to the diagnosis of adrenal tumor of the ovary. After removal of the tumor there was considerable regression of the masculinization.

Journal Pharmacology & Exper. Therapy, Baltimore

95:285-420 (March) 1949. **Partial Index**

Comparison of Effectiveness of Dihydroergotamine (DHE-45) and Dihydroergocornine (DHO-180) in Prevention of Cardiac Irregularities During Cyclopropane Anesthesia. W. D. Bennett, K. G. Dhuner and O. S. Orth.—p. 287.
Effect of Topically Applied Antihistaminic Drugs on Mammalian Capillary Bed. T. J. Haley and D. Harriette Harris.—p. 293.
Effects of Morphine, Codeine, and Dilaudid on Blood Flow. R. A. Huggins, C. A. Handley and M. La Forge.—p. 318.
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Antagonism for Fatal and Non-Fatal Doses of Quinine Intravenously in Depressed Circulatory States and Hyperthermia. R. H. Dreisbach.—p. 347.
Comparative Central Depressant Actions of Some 5-Phenyl-5-Alkenyl Barbituric Acids. G. A. Alles and C. H. Ellis.—p. 352.
Development of Resistance to Chlorguanide (Paludrine) During Treatment of Infections with Plasmodium Cynomolgi. L. H. Schmidt, Clara Sesler Genther, Rochelle Fradkin and Wanda Squires.—p. 382.
Altered Blood-Pressure Response After Adrenolytic Drugs and Large Doses of Sympathomimetic Amines. I. A. Coret and H. B. van Dyke.—p. 415.

New Orleans Medical and Surgical Journal

101:405-460 (March) 1949

Duodenal Ulcer: Appraisal of Current Methods of Medical Treatment. G. B. Eusterman.—p. 405.
Surgical Viewpoint of Leg Ulcer with Particular Reference to Post-Thrombophlebitic Ulcer. H. Mahorner.—p. 410.
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Allergic Hematuria Due to Milk: Report of Case. W. E. Kittredge and C. Johnson.—p. 419.
Obstructive Esophageal Lesions in Gastrointestinal Practice. G. McHardy and D. C. Browne.—p. 421.
Shortcomings of Certain Operative Procedures in Treatment of Pulmonary Tuberculosis. L. F. Knoepp.—p. 424.
Prolapse of Gastric Mucosa into Duodenum: Case Report and Analysis of Reported Cases. J. L. DiLeo, L. H. Kuker and R. M. Shepard.—p. 428.
Treatment of Heavy Metal Poisoning with British Anti-Lewisite (BAL). J. K. Howles.—p. 435.
Local Injection of Penicillin in Acute Circumscribed Infections. I. W. Kaplan and R. McDonald.—p. 440.
Management of Premature Labor. C. J. Lund.—p. 443.

Oklahoma State Medical Assn. Jour., Oklahoma City

42:43-86 (Feb.) 1949

Afflictions of Gastrointestinal Tract of Infant. P. E. Russo.—p. 46.
Surgical Lesions Involving Brain in Infancy. H. Wilkins.—p. 49.
Indications for Various Ophthalmic Operations. A. W. McAlester III.—p. 53.
Hypertension—Its Various Aspects and Treatment. F. R. Park.—p. 56.
Therapy with Children. H. J. Binder.—p. 59.

Surgery, St. Louis

25:329-488 (March) 1949

Collateral Circulation Following Ligation of Inferior Vena Cava: Injection Studies in Stillborn Infants. L. S. Robinson.—p. 329.
Tetraethylammonium Chloride in Evaluation of Lower Extremity Arterial Disorders. C. H. McIntyre, R. L. Marsh and J. D. Briggs.—p. 348.
Surgical Therapy of Duodenal Ulcer. J. H. Garlock and A. S. Lyons.—p. 352.
Comparative Study of Various Substances for Prevention of Adhesions about Tendons. E. C. Weckesser, B. W. Shaw, G. M. Spears and P. C. Shea.—p. 361.
Ruptures of Muscles and Tendons, with Particular Reference to Rupture (or Elongation of Long Tendon) of Biceps Brachii with Report of 50 Cases. R. L. Waugh, T. A. Hathcock and J. L. Elliott.—p. 370.
Motor Responses of Spatially Transposed Intestinal Loops. D. H. Watkins and F. C. Mann.—p. 393.
Mechanism of Shock in Peritonitis: Study of Hemodynamics of Shock Occurring in Peritonitis Experimentally Produced in Dogs. R. V. Ebert, P. S. Hagen and C. W. Borden.—p. 399.
Acute Perforations of Stomach and Small Bowel Ulcerations: Analysis of 362 Consecutive Cases. C. A. Luer.—p. 404.
Restoration of Grasping Function Following Loss of All Five Digits. B. Cannon, W. C. Graham and J. B. Brown.—p. 420.
Diagnosis of Lesions of Breast. W. T. Fitts Jr. and J. G. Donald.—p. 424.
Double Gall Bladders: Report of 4 Cases, One with Suppurative Cholangitis and Bacteremia. N. F. Hicken, V. L. Stevenson, L. M. Allen and C. R. Cornwall.—p. 431.
Duodenal Diverticulitis with Perforation: Report of Case. W. L. Byerly Jr.—p. 441.
Effect of Surgical Devascularization of Stomach on Production of Mann-Williamson Ulcers. B. Holm and A. G. Mackay.—p. 446.
Method for Producing Coarctation of Thoracic Aorta in Dogs. W. C. Sealey and G. H. McSwain.—p. 451.

Virginia Medical Monthly, Richmond

76:105-158 (March) 1949

Regional Ileitis: Report of 2 Cases with Summary of Literature. W. P. Barnes.—p. 107.
Diagnosis and Treatment of Malignant Tumors of Ovary. C. B. Morton II.—p. 115.
Relation of Food Allergy to Nutrition, Disease, and Behavior in Childhood. B. B. Jones.—p. 118
*Present Status of Para-Aminobenzoic Acid Therapy in Rocky Mountain Spotted Fever. C. G. Hooten Jr., W. S. Hooten and J. E. Mitchell.—p. 121.
Pregnancy Complicated by Primary Torsion of Normal Fallopian Tube. C. L. Riley.—p. 127.
Case of Anuria During Combined Sulfonamide Therapy. W. R. Chitwood and A. E. LeHew.—p. 128.
Pulmonary Tularemia with Report of 2 Cases. G. B. Craddock and R. V. Crowder Jr.—p. 130.
Uniocular Hysterical Amaurosis. F. V. Gammage.—p. 135.

Para-Aminobenzoic Acid in Rocky Mountain Spotted Fever.—Hooten, Hooten and Mitchell point out that Rocky Mountain spotted fever was first thought to occur only in the area for which it is named, but it has since been reported from every section of the United States. They review previous reports on the use of para-aminobenzoic acid in the treatment of this condition and the experiences with this drug in 12 cases treated by themselves and in 48 cases from the literature. Seven of the 12 patients treated by them are reported in detail. The amount of para-aminobenzoic acid required varies, but the blood level should be maintained between 20 and 60 mg. per hundred cubic centimeters. In adults this level can usually be maintained by an initial dose of 8 Gm. and then 2 Gm. every two hours. The 48 cases from the literature and the 12 cases just reported show an almost uniformly good response to treatment with para-aminobenzoic acid. There were 4 deaths (mortality rate of 6.7 per cent). Clinical improvement was usually noted in twenty-four to forty-eight hours after the beginning of para-aminobenzoic acid therapy, and the duration of fever was about one week shorter than in patients who did not receive the drug. The authors feel that para-aminobenzoic acid is now the drug of choice in the treatment of Rocky Mountain spotted fever.

FOREIGN

An asterisk (*) before a title indicates that the article is abstracted. Single case reports and trials of new drugs are usually omitted.

Archives of Disease in Childhood, London

24:1-80 (March) 1949

Malignant Disease in Infancy and Childhood. W. F. Gaisford.—p. 1.
Bromsulphalein Excretion in the Newborn. P. L. Mollison and Marie Cuthbush.—p. 7.
Liver Function in Newborn Infants with Special Reference to Excretion of Bromsulphalein. S. Yudkin and S. S. Gellis.—p. 12.
Liver Damage in Gastro-Enteritis. B. Schlesinger, W. W. Payne and E. D. Burnard.—p. 15.
Spina Bifida Cystica. A. P. Norman.—p. 25.
*Pulmonary Collapse in Pertussis. D. P. Nicholson.—p. 29.
Arobon in Treatment of Infantile Gastro-Enteritis: Clinical Trial. D. Beynon.—p. 41.
Epidemic Gastro-Enteritis of Infants in Aberdeen During 1947. C. Giles, G. Sangster and J. Smith.—p. 45.
Roseola Infantum: Outbreak in Maternity Hospital. U. James and A. Freier.—p. 54.

Pulmonary Collapse in Pertussis.—Nicholson reviews the literature relating to pertussis and bronchiectasis and presents observations on a series of 44 children with pertussis, most of them with a type severe enough to warrant admission to a hospital. These children were examined frequently. The shadows seen on the radiographs were usually typical of lobar or segmental collapse, mainly of the middle and lower lobes. Evidence in favor of the shadows representing collapsed lobe was as follows: (1) physical signs of collapse and lack of response to chemotherapy; (2) association of mediastinal shift and compensatory emphysema; (3) the presence in some radiographs of visibly dilated bronchi in the shadow; (4) the similarity of the shadows with the triangular basal shadows. Collapse of over two months' duration was seen in 1 out of 4 mild cases, 9 out of 16 moderate cases, and 13 out of 17 severe cases, that were followed for a sufficient length of time. If collapse is still present after the acute stage is over further treatment is imperative, and should be directed at the collapsed lobe. Postural drainage in the appropriate position should be given and this should be combined with percussion over the affected lobe in an attempt to induce the child to cough up the particles of sputum. Treatment in this manner can be given several times a day and must be given until all hope of re-expansion is abandoned. If reexpansion does not occur within nine months it is unlikely to do so, and bronchiectasis may supervene and surgery may become necessary. Many cases of postpertussis pulmonary collapse still go unrecognized, and all too often the treatment consists of an ineffective cough mixture.

British Journal of Radiology, London

22:123-182 (March) 1949

Radiographic Studies Showing Induction of Segmentation Pattern in Small Intestine in Normal Human Subjects. A. C. Frazer, J. M. French and M. D. Thompson.—p. 123.
Bronchography—Methods by Which it May Be Performed and Factors Influencing Choice of Method Employed: Part I. A. A. Vickers. —p. 137.
Pulmonary Actinomycosis. S. F. Oosthuizen and M. H. Fainsinger. —p. 152.
Estimation of Bi-Spinous Diameter in Pelvimetry. J. B. Hartley. —p. 156.
Simple Apparatus for Aimed Exposures. S. D. Kilner.—p. 158.
Clinical Radiation Dosage. L. Cohen.—p. 160.
Random Purification Apparatus. H. C. Sutton.—p. 164.
Construction and Performance of High Pressure Condenser Ionization Chamber. F. W. Spiers.—p. 169.
Tangential Irradiation Without Use of Bolus Packing. J. R. Clarkson. —p. 173.

British Medical Journal, London

1:511-556 (March 26) 1949

Propagation of Mouse Tumours by Means of Dried Tissue. W. E. Gye.—p. 511.
Long-Term Cardiac Observation of Children. R. K. Price.—p. 515.
Hog-Stomach Extract and Casein Hydrolysate in Peptic Ulcer. A. W. Kay, R. A. Jamieson and W. E. Smith.—p. 519.
Hyperinsulinism Due to Islet-Cell Adenoma: Cure, with Metabolic Studies Before and After Operation. W. G. D. Murray.—p. 521.
Ringworm of Scalp: Treatment by X-Ray Epilation Without Subsequent Local Application. F. L. Lydon, T. Stephanides and T. M. Robb. —p. 523.
Fulminating Meningococcal Septicemia: Account of Three Cases, with One Recovery. P. Turner and R. V. Dent.—p. 524.
Nomograms for Sling and Assmann Psychrometers. J. B. de V. Weir. —p. 527.

Irish Journal of Medical Science, Dublin

279:97-140 (March) 1949

Dublin Surgery 100 Years Ago. W. Doolin.—p. 97.
*Pneumoperitoneum and Phrenic Paralysis in Treatment of Pulmonary Tuberculosis: Report on 188 Cases. M. Hanrahan.—p. 112.
Note on Use of Radium in Conjunction with Surgery in Gynecology. R. E. Tottenham.—p. 125.

Pneumoperitoneum and Phrenic Paralysis.—Hanrahan treated 57 patients with pulmonary tuberculosis with pneumoperitoneum only. Quiescence was achieved in 1 case and improvement in 21 cases; in 11 cases the condition was unchanged and in 24 it became worse. Pneumoperitoneum alone seems to be of little or no benefit, and it should be abandoned or used sparingly. Phrenic paralysis reinforced by pneumoperitoneum was carried out in 131 patients with pulmonary tuberculosis. Quiescence was achieved in 25 cases and improvement in 57; 19 patients were unchanged and 30 became worse. These results show that the majority of cases will require some other form of treatment if quiescence is to be achieved. In 6 of 43 patients in whom pneumoperitoneum and phrenic paralysis had been instituted after attempts to induce pneumothorax had failed the disease became quiescent; 24 in this group were improved; 7 were unchanged and 6 deteriorated, suggesting that pneumoperitoneum and phrenic paralysis are of little value in cases in which visceral and parietal pleurae are widely adherent. Quiescence was established in 12 patients, and 15 were improved in a group of 38 patients in whom pneumoperitoneum and phrenic paralysis were instituted after abandonment of pneumothorax because of fluid or contralateral spread, thus giving a good prospect of satisfactory results following the abandonment of pneumothorax. Quiescence was established in 5 patients, and 4 were improved in a group of 10 patients in whom phrenic paralysis and pneumoperitoneum were instituted complementary to pneumothorax, suggesting that this combined treatment deserves further trial. Results were best with pneumoperitoneum and phrenic paralysis in lower zone disease with cavitation below the hilus, when a partial pneumothorax was conducted simultaneously and where the pleura was relatively free, i. e., after pneumothorax had been abandoned. Pneumoperitoneum and phrenic paralysis had a favorable effect in only a small proportion of cases of cavitation situated above the hilus. Each case must be judged on its merits, and if the treatment is having the desired effect phrenic paralysis and pneumoperitoneum should be maintained for at least three years.

Journal of Mental Science, London

95:1-262 (Jan.) 1949. **Partial Index**

What the Patient Thinks. W. Rees-Thomas.—p. 1.
Electric Anesthesia and Electro-Narcosis. E. O. Longley.—p. 51.
Leukotomy in Periodic Psychoses. G. N. Jones and P. K. McCowan. —p. 101.
Results of Isolation of Orbital Lobes in Leukotomy. G. Egan.—p. 115.
Environment as Factor in Etiology of Criminal Paranoia. K. O. Milner.—p. 124.
Pupillary Phenomena on Application of Strong Constant Electric Current as Used in Electronarcotic Treatment. R. Klein and D. F. Early. —p. 140.
Nasopalpebral Reflex: Its Application to Neuro-Psychiatry, Particularly to Insulin Shock Treatment. F. F. Kino.—p. 143.
Note on Ammonia and Glutamine Content of Cerebrospinal Fluid. D. Richter, R. M. C. Dawson and L. Rees.—p. 148.
Adrenal Cortical Steroids and Metabolism of Glutamic Acid in Gluconeogenesis. W. R. Ashby.—p. 153.
Physiologic Concomitants of Electronarcosis. L. Rees.—p. 162.
Anatomic Correlates of Improvement after Leukotomy. T. McLardy and A. Meyer.—p. 182.
*Transorbital Leukotomy. G. W. T. H. Fleming and D. G. Phillips. —p. 197.
*Chess as Form of Recreational Therapy. R. Pakenham-Walsh.—p. 203.

Transorbital Leukotomy.—Fleming and Phillips review observations of 8 patients who had been subjected to transorbital leukotomy. The technic employed was that described by Freeman. Although all of these patients had a poor prognosis, 7 of the 8 patients showed improvement after transorbital leukotomy. Of 5 patients with depression, 1 recovered completely and the other 4 were improved. One patient with paranoid schizophrenia recovered; another schizophrenic patient was much improved, but a third one appeared to be worse. Two of these patients could not have been operated on by ordinary leukotomy without great risk.

Chess in Recreational Therapy.—Pakenham-Walsh discusses his experience with chess games in a mental hospital. Although the object of this report is mainly to stimulate similar activity in other mental hospitals and to bring chess into line with cricket and football, so that interhospital matches could be arranged, he suggests that chess is not merely another form of recreation therapy but that it is an intelligence test of which much use could be made. If a player were to play a series of recorded games both before and after leukotomy, it might be possible to detect changes not only in the intelligence but in the personality, e. g., the cautious player might become reckless, or the man who plays a good attacking game might change to a defensive player.

Journal of Tropical Medicine and Hygiene, London

52:45-66 (March) 1949

Strongyloides Stercoralis Infection. Part II. Strongyloidiasis Among Ex-Prisoners-of-War. L. E. Napier.—p. 46.
Protozoologic and Helminthologic Survey of Three Races in Nairobi, Kenya. J. I. Roberts.—p. 49.
Tribal Distribution of Bilharzia in East Africa. K. E. Dewhurst.—p. 60.

Lancet, London

1:509-552 (March 26) 1949

At the Cross-Roads: Development of Health Services. A. L. Banks. —p. 509.
Action of Dihydroergocornine on Circulation with Special Reference to Hypertension. R. H. Goetz.—p. 510.
Immediate Results of Partial Gastrectomy for Peptic Ulcer. B. B. Milstein.—p. 514.
Agranulocytosis and Thrombocytopenia Following Use of Tridione. T. W. Forster, J. W. Watson and E. Neumark.—p. 517.
*Necrotic Jejunitis. K. A. Fick and A. P. Wolken.—p. 519.
Effect of Intra-Uterine Radium Therapy on Ovarian Function. Gertrude Goldscheider.—p. 521.
*Use of Thrombin in Liver Puncture. L. Friedrich and M. Policzer. —p. 523.

Necrotic Jejunitis.—Fick and Wolken direct attention to an apparently endemic, severe and often fatal lesion of the jejunum, observed during the past few years in Northern Germany. Though sometimes there is a short prodromal stage, the onset is usually acute with violent pain in the upper part of the abdomen. Often the pain is located a little to the left of the midline and is associated with a hyperesthetic Head zone from the seventh to the twelfth thoracic segment on the left side and a reflex rigidity of the abdominal wall in the same segments. At the same time the patient usually suffers from nausea and vomiting. The most striking clinical feature is circulatory collapse due to toxemia. The patient may die within twenty-four hours after the onset of the first symptoms. Those who survive this stage pass into either a condition characterized by enteritis with bloodstained diarrhea or a condition of intestinal obstruction resembling paralytic ileus. The histologic picture in the gut is that of fairly generalized necrosis. The disease is thought to be a specific infection to which one is predisposed by defects of diet. Since this paper was written, a new bacillus has been discovered in the intestinal lumen in some cases of jejunitis by Zeissler of Hamburg. This bacterium, previously unrecognized, is an anaerobe of the Clostridium welchii group. It forms a powerful toxin. It is closely related to another bacillus of the same group of Cl. welchii, which causes dysentery in lambs, a condition characterized by severe enteritis. Zeissler holds that his organism, which he names Clostridium enterotoxicus or Cl. welchii type F, plays an important part in the causation of jejunitis. It has also been found in healthy persons in Northern Germany. Should further research confirm Zeissler's opinion about this organism, it would also confirm the opinion held by the authors that necrotic jejunitis is a specific infection the manifestation of which depends on certain other factors.

Thrombin in Liver Puncture.—According to Friedrich and Policzer of Budapest, the greatest risk in liver puncture is hemorrhage. After satisfying themselves that it did no harm to the liver tissue in the cadaver, the authors adopted a method in which commercial thrombin is injected into the needle track after the biopsy specimen is withdrawn. The thrombin is provided in powder form. The solvent, put up in separate phials, contains pyrocatechin and calcium chloride, to enhance thrombin activity, and sodium chloride and tricresol, to insure sterility and stability. The authors have obtained the best effects with a solution containing 200 coagulation units in 1 cc. of solvent. The liver puncture needle used is double, the outer needle being 12 cm. long and 2 mm. in bore and the inner 1.4 mm. in bore and fitted with a stylet. The outer needle is graduated in centimeters, and a depth screw is provided to control the depth of the puncture. Apart from the effect of thrombin solution, the authors ascribe the freedom from complications in their cases to the use of a needle which will not pass more than 3 cm. into the liver.

Medical Journal of Australia, Sydney

1:153-184 (Feb. 5) 1949

Bill for Act to Provide for Establishment of National Health Services, and for Other Purposes.—p. 153.

1:185-224 (Feb. 12) 1949. **Partial Index**

*Resection of Lung Tissue for Pulmonary Tuberculosis. C. J. Brown. —p. 185.
Anesthesia in Surgical Treatment of Pulmonary Tuberculosis. R. H. Orton.—p. 189.
Limitations of Role of Radiologist in Diagnosis of Pulmonary Tuberculosis. K. H. Hallam.—p. 193.
Sinusitis in Children. S. Pearlman.—p. 197.
X-Ray Interpretation of Pulmonary Tuberculosis in Childhood. C. Macdonald.—p. 200.
Radiologic Interpretation and Pulmonary Tuberculosis in Adult. M. R. de Lambert.—p. 203.
Pulmonary Tuberculosis in the Elderly. K. H. Hallam.—p. 206.

Resection of Lung for Pulmonary Tuberculosis.—Brown lists the following conditions as indications for pulmonary resection in tuberculous patients: (1) high grade bronchial stenosis, with or without associated suppurative disease; (2) tuberculoma; (3) cavity persisting after thoracoplasty; (4) lower lobe cavities which have resisted other methods of treatment, and (5) massive acute tuberculosis which is unilobar or unilateral, when the patient's condition is deteriorating, despite bed rest and streptomycin. He reviews his experiences in 11 pneumonectomies and 7 lobectomies and stresses that resection has established itself as a valuable treatment in certain forms of pulmonary tuberculosis. It is not an alternative to thoracoplasty, but should be used for cases in which thoracoplasty is inapplicable or has failed. Most of the patients selected for resection have no other chance of getting well, and the undoubted risks are justified by the successes. Streptomycin is probably of real value to cover the immediate postoperative period and to control postoperative spread.

South African Journal Med. Sciences, Johannesburg

13:145-182 (Oct.) 1948

Effect of Pituitrin upon Performance in Moderate Heat. W. S. S. Ladell.—p. 145.
Effect of 2,3-Dimercaptopropanol (British Anti-Lewisite) on Toxicity of Neoarsphenamine for Ornithodorus Moubata. J. M. Thorp, B. De Meillon and F. Hardy.—p. 151.
Relationship Between Ectoparasite and Host. III. Development of Cimex Lectularius on Vitamin A-Deficient Rabbits, with Some Observations on Effect of Calcium Technic. B. De Meillon, J. M. Thorp, F. Hardy and J. N. Mentz.—p. 159.
*Structure of Liver in Fatal Burns. J. Gillman and T. Gillman.—p. 169.

The Liver in Fatal Burns.—The 38 patients examined by the Gillmans had not received tannic acid in the treatment of their burns. They had died from burns within one hour and as long as thirty-six days after the accident. The authors observed three main types of reactions, namely, loss of stainability of the liver cells, fatty changes and atrophy of cells in the central zone of the lobule. Loss of stainability was seen mainly in the livers of patients dying within forty-eight hours after the accident. Fat, in the form of small and medium-sized droplets, could appear as early as eighteen hours, but it was more consistently observed between thirty-six and seventy-two hours after the accident. Atrophy of the liver cells around the central vein becomes manifest first in a liver thirty-six hours after burns are sustained. The extensive necrosis described in different parts of the world was not observed in this series of cases, probably because tannic acid had not been used on the burns of these patients. Tannic acid presumably intensifies the tendency to necrosis. The authors conclude that in the majority of fatal cases of burns the morphologic changes in the liver were insufficient to account for death. If the liver does contribute to death it does so chemically.

Acta Medica Scandinavica, Stockholm

132:507-610 (Feb. 28) 1949

Influence of Adrenalin on Blood Sugar and Blood Ketone Bodies in Normal Individuals and in Patients Suffering From Hepatic Disease. A. Warming-Larsen.—p. 507.
*Spontaneous Pneumohemothorax. J. L. Hansen.—p. 517.
Treatment of Heart Block with Adrenergic Substances. E. Roelsen. —p. 534.
Spontaneous Hypoliquorrhea: Report of Case. T. Lindqvist and E. Moberg.—p. 556.
Haverhill Fever (in Connection with Case Observed in Sweden). A. Engel.—p. 562.
Artificial Kidney: VI. Views on Indications for Treatment of Uremia and for Active Removal of Edema by Means of Artificial Kidney, Based on Studies of Uremic Material not Treated with this Method. N. Alwall and B. Herner.—p. 572.
*Id.: Clinical Experiences of Dialytic Treatment of Uremia. N. Alwall, L. Norviit and A. M. Steins.—p. 587.

Spontaneous Pneumohemothorax.—Hansen presents 3 cases of spontaneous pneumohemothorax treated at a clinic of thoracic surgery during the spring of 1946. None of them were typical. The symptoms in the first case differed from the usual only in the onset. The patient was hospitalized with a diagnosis of perforated gastric ulcer and was then treated for heart disease. This is by no means a rare variant of the syndrome, and its recognition is important. The other 2 patients exhibited bilateral cystic lung. This cause does not appear to have been observed in the cases published hitherto, or at any rate, not in this form. One of the 2 patients was a woman and one of the few patients over the age of 40 with this type of disorder. In this patient the diagnosis was proved by an operation performed as the last resort after the disease had lasted nineteen days and the symptoms had grown worse. The cysts were so close together that suture of the numerous ruptures was impossible. Thirty-six hours later the patient died in anoxia. Necropsy showed the cysts in both lungs to be so extensive that the normal lung tissue capable of respiration was reduced to practically nothing. A number of the cysts had ruptured. The origin of the hemorrhage could not be demonstrated. In the third patient, a youth of 21, suddenly, without exertion, there developed a pneumohemothorax with severe intrapleural tension which quickly subsided after thoracocentesis. Roentgenographic as well as thoracoscopic examination revealed a cystic lung. In spite of bed rest, closed pulmonary fistula and a constant negative pressure, the right lung showed no tendency to expand. After five weeks a solution of silver nitrate was injected into the pleural cavity. The result was an adhesive pleurisy with rapid expansion of the lung.

Artificial Kidney: Clinical Experiences.—Alwall and associates report experiences with dialysis in the first 12 patients treated with a dialyzer of a type in which the cellophane tubing is wrapped round a cylinder of wire netting and is surrounded by a mantle of the same material. In 2 of the 12 reported cases the treatment was repeated after intervals of forty-five and eight days, respectively. Thus, fourteen treatments were given in these 12 cases. Uremia was the reason for dialytic treatment in 9 of the cases, and in 2 severe edema as well as uremia was present. In most of the cases the treatment was carried out under conditions precluding a lasting therapeutic result. The material can thus only show that the method can have therapeutic value, but not to what extent good therapeutic results are to be expected. It offers many valuable experiences for future work.

Deutsche medizinische Wochenschrift, Stuttgart

74:321-352 (March 18) 1949. **Partial Index**

Bechterew's Disease and Scleroderma; Sclerodystrophic Systemic Diseases. E. Vaubel.—p. 321.
*Usefulness of Maclagan's Thymol Turbidity Test for Differential Diagnosis of Icterus. K. Denninger and A. Goedtler.—p. 326.
*Early Diagnosis of Carcinoma of the Cardia. N. Henning.—p. 329.
Respiratory Insufficiency in Cases of Impediment of Respiratory Movements. H. C. Landen and Ewalda Sürder.—p. 331.

Thymol Turbidity Test in Icterus.—Denninger and Goedtler performed Maclagan's thymol turbidity test of hepatic function on 104 patients, 72 of them with icterus and 32 control patients in whom history and clinical examination did not suggest any disease of the liver or of the biliary ducts. The result of the thymol turbidity test was negative in all 32 control patients and in 33 patients with mechanical icterus resulting from obstruction by tumor or stones. The result of the thymol turbidity test was positive in all 36 patients with icterus resulting from parenchymatous disease of the liver. The reaction was negative in only 3 patients with icterus and a partly positive Takata reaction in whom the clinical picture suggested a parenchymatous disease of the liver; the icterus, which might have been mechanical, subsided within a few weeks. In patients with chronic, latent, diffuse hepatic disease, the result of the thymol turbidity test was always positive. It is a reliable index of liver dysfunction in cases of this type. The thymol turbidity test is of great value in the differential diagnosis of jaundice. A great advantage is the technical simplicity of the test.

Carcinoma of the Cardia.—Henning reports 52 cases of carcinoma of the cardia in 40 men and 12 women between the ages of 34 and 77. Symptoms were present two months to one year. The first subjective sign was painless dysphagia. Results of roentgenologic examination suggested carcinoma of the fornix involving the cardia in 24 cases; carcinoma was suspected in 20 cases, and cardiospasm was diagnosed in the remaining 8 cases. Endoscopic examination was performed in all 52 cases. The predominant observations in 20 of these cases were a rigid cardia and a more or less narrowed lumen with angular borders. Neoplastic changes above the cardia were not visible. In other cases signs of growth penetrating the wall of the esophagus above the cardia were manifested by a blackish lumen surrounded by four oval, sharply delineated, whitish, flat areas shaped like the jasmin flower. This characteristic picture is a definite aid in differential diagnosis from cardiospasm. Early diagnosis is possible in a much larger percentage of cases of carcinoma of the cardia than carcinoma of other parts of the digestive canal, provided that roentgenologic examination and esophagoscopic examination are performed early for patients with initial dysphagia.

Lyon Chirurgical

44:129-256 (March-April) 1949. **Partial Index**

*Forty-Five Blalock Operations for Congenital Cyanosis. P. Santy, M. Bérard, J. Bret and P. Marion.—p. 129.
*Thoughts on Raynaud's Disease with Regard to 35 Observations. P. Wertheimer and R. Guillet.—p. 145.
Modern Treatment for Considerable Destruction of Coverings of Extremities by Trauma. F. Lagrot.—p. 158.
Condition of Cystic Degeneration of Preserved Ovaries. C. Roman. —p. 162.

Blalock Operation for Congenital Cyanosis.—Santy and co-workers performed the Blalock operation on 23 boys and 22 girls, between the ages of 23 months and 15 years, from a group of 100 children with congenital cyanosis. The operation was performed only in those children in whom deficient pulmonary circulation had been diagnosed on clinical and roentgenologic examination. In 1 case in which the Blalock operation was attempted, it could not be performed because no pulmonary artery was present on the surgically treated side. In all patients operated on the subclavian artery was used for the anastomosis with the pulmonary artery. As a general rule the anastomoses were carried out by the end to side technic. The anastomosis of the subclavian artery with the pulmonary artery by the end to end method of suture warrants satisfactory functional results and is to be considered safe in difficult cases in which the end to side method appears to be technically impossible. There were 5 operative deaths, 3 from cardiac syncope and 2 from diffuse venous hemorrhage. Five additional patients died in one to thirteen days after the operation, 2 of them from pulmonary edema, 1 from septicemia and 1 from empyema. In 3 operation failed, in 1 because of the absence of the right pulmonary artery and in 2 because of the poor permeability of the anastomosis. The operation was successful in 32 patients with complete transformation of the clinical and roentgenologic symptoms.

Raynaud's Disease.—Wertheimer and Guillet report on 35 patients, 20 women between the ages of 23 and 68 and 15 men between the ages of 24 and 70, with Raynaud's disease. The patients had vasomotor disturbances of the extremities manifested by paroxysmal attacks of vasoconstriction from cold, and 26 had ulcerations of the subungual pulp. The average duration of

symptoms was ten years. Nineteen patients had mild disturbances in the lower extremities and 6 had severe destructive lesions of the distal part of the upper extremities. Satisfactory results were obtained with periarterial sympathectomy in 2, partial results in 5 and failures in 5. Stellectomy was performed by cervical approach in 35 instances without any serious incident. There was clinical improvement, particularly of the trophic lesions. A cure was obtained only in exceptional instances; sensibility to cold and vasomotor attacks usually persisted, although they were improved. Operation on the thoracic chain of the sympathetic trunk was done in 4 cases, but the follow-up period had not been long enough for definite conclusions. Combined with stellectomy, it may yield more constant results. Surgical treatment should be carried out in this direction, since the value of intervention on the thyroid, parathyroids and adrenals has not been established. The pathogenesis of Raynaud's disease is still unknown.

Nordisk Medicin, Stockholm

41:343-390 (Feb. 25) 1949. **Partial Index**

Surgical Treatment of Facial Palsy. H. Schjelderup.—p. 343.
Question Technic in Obtaining Anamnestic Date in Nervous Diseases. T. Broman.—p. 349.
Tonsillectomy According to Sluder-Ballenger in Children: After-Examination of 296 Children. A. Bydal.—p. 354.
Causes of Death in Pharyngeal Diphtheria. J. Riis.—p. 357.
*Increased Poliomyelitis Morbidity in Older Age Groups and Its Causes. S. Wernstedt.—p. 361.
*Tests of Air Disinfection by Triethylene Glycol. E. Gedda.—p. 363.
Treatment of Peripheral Facial Palsy in Fractures of Cranial Base. W. Behrman.—p. 368.
Plasma Cell Tumor (Plasmocytoma) in Paranasal Sinuses. P. Berdal. —p. 369.
Penicillin Lavage in Paronychia Tendinosa. A. Langvad-Neilsen. —p. 371.
New Method of Treating Infected Atheroma. O. Arner.—p. 374.
Encephalography in Frontal Lobotomy. B. Köhler.—p. 377.

Increased Poliomyelitis Morbidity in Older Age Groups and Its Causes.—Wernstedt says that, with increased urbanization in country districts in Sweden in recent years, improvements in road systems and means of travel and more intensive movement to the cities, persons of low immunity from rural districts have been brought into livelier contact with urban populations and have been exposed to greater risk of poliomyelitis infection. This applies particularly to older children and adults, who are mainly the ones to travel and to settle in cities and densely populated areas for purposes of education or employment in industry or trade. The result has been an increase in the incidence of poliomyelitis in these age groups.

Tests of Air Disinfection by Triethylene Glycol.—Gedda reports on two series of tests of the efficacy of air disinfection with vaporized triethylene glycol in public places—a clinic waiting room and a children's home nursery. Similar tests of bacterial concentration without the use of glycol were carried out for the same number of days. Bacterial count with the Bourdillon apparatus showed an average reduction of about 30 per cent in the first series and about 40 per cent in the second. The relative humidity was 35 to 60 per cent in the waiting room and 70 to 80 per cent in the nursery.

Pediatria, Naples

57:1-116 (Jan.-Feb.) 1949. **Partial Index**

*Penicillin in Therapy of Gonococcic Vulvovaginitis in Little Girls. A. Visani.—p. 1.
*Penicillin Aerosols in Treatment of Nontuberculous Diseases of Lung. M. Scarzella.—p. 12.

Penicillin Therapy of Gonococcic Vulvovaginitis.—Visani treated gonococcic vulvovaginitis in 13 girls between the ages of 4 and 10 years. The disease was chronic in 9 and acute in 4. Previous sulfonamide therapy and local antiseptic treatment with or without vaccines had failed. Penicillin was given intramuscularly in doses of 20,000 units every three hours up to a total of 300,000 units. Local penicillin treatment was continued for ten days after discontinuation of the systemic treatment. The treatment was well tolerated. The secretion rapidly became negative for gonococci. Cure for more than one year was obtained in the 4 cases of acute disease and in 7 of chronic disease. Two of the patients with chronic disease had either a recurrence or a reinfection one year after discontinuation of the penicillin therapy, which was repeated successfully. The treatment failed in 2 cases of chronic disease. Penicillin therapy is of great value in gonococcic vulvovaginitis in young girls. In patients who do not react favorably to the treatment, the administration of autovaccines and of estrogens, before or combined with systemic and local penicillin treatment, is indicated.

Penicillin Aerosols in Diseases of Lung.—Scarzella practiced penicillin aerosol treatment in 52 patients with various types of nontuberculous infection of the lung. The group included 47 infants and children and 5 young adults. The daily dose of penicillin used in the preparation of aerosols varied from 25,000 to 50,000 units. The treatment was given every eight hours for ten to fifteen minutes for a series of ten or twelve treatments. Best results were obtained in acute abscess of the lung, in acute and chronic bronchitis and in bronchiectasis without pulmonary fibrosis. The improvement from the treatment was moderate in chronic abscess of the lung and in bronchiectasis with fibrosis. In all cases fever disappeared, the patient's general condition improved, the amount of sputum diminished and the sputum became odorless. Penicillin aerosols proved to be of great therapeutic value in chronic rhinopharyngitis, especially when it was complicated with otitis. The treatment is also of value in adenoiditis and in inflammation of the lymphatic ring after tonsillectomy.

Praxis, Bern

38:249-278 (March 24) 1949. **Partial Index**

Where are We Standing in Fighting Tuberculosis? A. Grumbach. —p. 249.
*Vaccination Against Tuberculosis. A. Delachaux.—p. 253.
*Importance of Tuberculous Bovine Infection for Man. H. Wissler and P. Meister.—p. 259.
Increased Incidence of Anicteric Hepatitis. W. Fritschy and U. Stäubli.—p. 261.

Vaccination Against Tuberculosis.—Delachaux reports statistical data concerning student nurses in three hospitals in the French section of Switzerland. During the period of 1935 to 1942, before BCG vaccination was instituted, the rate of infection was 14 per cent among the nurses with a negative skin reaction. BCG vaccination during the period of 1943 to 1947 reduced the rate of infection to 3 per cent; the morbidity rate of vaccinated negative reactors as compared with nonvaccinated negative reactors is 1:4.7. BCG vaccination may be carried out exclusively on anergic persons, i. e., on those with a negative skin reaction to tuberculin in Mantoux's test with 1 mg. old Koch's tuberculin or 100 units of its protein purified derivative which elicits an infiltrate of a diameter less than 8 mm. There is little untoward reaction, provided that BCG is applied correctly by the parenteral route. Applied incorrectly, BCG causes disturbances only in an area strongly allergic to tuberculin. BCG is less apt to elicit local, focal or general reactions than the tuberculin. BCG acts by replacing the natural primary inoculation, which always involves a great risk because of its possible virulence. BCG induces an effective protection against the primosecondary complications. Immunity against pulmonary phthisis is less absolute but is highly demonstrative with a morbidity rate among persons vaccinated with BCG as compared with those not vaccinated, varying from 1:3 to 1:5. BCG vaccination may be carried out on anergic persons whatever the age but is indicated particularly for persons between the ages of 13 and 25, because of the lesser resistance of these persons to tuberculous infection. Vaccination against tuberculosis is imperative in anergic persons who are exposed frequently to Koch's bacillus in their families or in their occupation. Vaccination against tuberculosis does not exclude other current prophylactic measures.

Tuberculous Bovine Infection.—Wissler and Meister report on 65 cases of tuberculosis of bones and joints in children admitted to the sanatorium in Davos Platz, Switzerland. Thirty-seven of these had definite pulmonary tuberculosis in the sense of a primary complex; 5 had doubtful pulmonary tuberculosis; calcified mesenteric lymph nodes were present in 7 patients; 4 presented tuberculous cervical lymphoma, and in 12 patients the localization of the primary complex was not determined. Bovine infection may be conveyed to man almost exclusively by food, leading to primary foci in the intestine or in the oral cavity. Cervical lymphoma may be considered as the clinical manifestation of primary infection of the oral cavity, and tuber-

culous mesenteric lymph nodes may be considered as the clinical manifestation of primary intestinal infection. Bovine infection was responsible for 11 cases in the authors' series. Nineteen patients had tuberculous spondylitis; an additional 19 had coxitis; 14 had gonitis, and 13 presented various localizations. Permanent damage in the form of ankylosis may be expected in 7 of the 11 cases. Bovine infection plays an important part even among the limited number of patients in a children's sanatorium.

Revista Clínica Española, Madrid

32:1-62 (Jan. 15) 1949. **Partial Index**

*Syndrome of Pulmonary Hyperventilation. C. Jiménez Díaz.—p. 15.
*Penicillin Treatment as Test for Differential Diagnosis of Abacteric Endocarditis Lenta and of Certain Forms of Rheumatic Fever. F. De A. Estapé.—p. 32.

Syndrome of Pulmonary Hyperventilation.—Jiménez Díaz calls attention to the clinical significance of permanent spontaneous pulmonary hyperventilation in normal persons as causative of the effort syndrome. The syndrome is more frequent in young adults and is more frequent in men than in women. It has its origin in a constitutional sympathetic dystonia. It is aggravated by emotion, changes of environmental temperature and physical effort. Alkalosis ensues with consequent cephalic and peripheral anoxia, various metabolic disorders, hypotension and crises manifested by anguish, abdominal vagal disorders, precordial pain, tachycardia, fainting, dizziness, humming noises, cold perspiration, formication and paresthesia of the limbs. Differential diagnosis between the syndrome of pulmonary hyperventilation and the so-called effort syndrome in patients with heart disease or with neurosis is confirmed by provoking pulmonary hyperventilation of two or three minutes' duration, which results in the production of the acute symptoms. The preventive treatment consists in training the patient to control his emotions. Sedatives, intravenous injections of calcium, an acid diet and training the patient to breath with abdominal muscles are of some value. During the acute attack the patient should be made to inhale a gaseous mixture surcharged with carbon dioxide.

Penicillin as Test for Diagnosis of Endocarditis Lenta.—Estapé reports 3 cases of endocarditis lenta. Subacute bacterial endocarditis may exist in the presence of negative blood cultures. The differential diagnosis of true subacute endocarditis with negative blood cultures is at times difficult to make. Penicillin therapy in adequate doses and for sufficient duration constitutes the best method of arriving at a differential diagnosis. When the response is nil or is sluggish, the doses can be increased and the period of treatment extended to five weeks. In bacterial endocarditis four or five weeks is the minimum necessary time to check the infection. Penicillin is effective in subacute endocarditis with negative blood cultures. It is only in subacute abacterial pseudoendocarditis and in subacute rheumatism that penicillin is ineffective. In cases of erroneously diagnosed rheumatic fever with positive penicillin therapy, bacterial endocarditis of unknown origin is most likely present.

Strasbourg Médical

109:43-54 (Feb. 5) 1949

*Neurologic Symptoms in Patients with Gastroduodenal Ulcers. J. Warter and A. Fitzenkam.—p. 43.
*Treatment of Parotitic Orchitis by Infiltration of Lumbar Sympathetic Nerve. J. Morin.—p. 46.
New Encephalosurgical Method. Chemical Surgery of Nerves. M. Lopez Esnaurrizar.—p. 49.
Treatment of Burns. R. Krafft.—p. 51.

Neurologic Symptoms in Gastroduodenal Ulcers.—Warter and Fitzenkam report 72 patients with gastroduodenal ulcers demonstrated by roentgenologic study and in 41 by surgical intervention. The patients presented neurologic symptoms of vestibular type. Sixty-eight (more than 90 per cent) had disturbances of equilibrium manifested by a spontaneous deviation of the stretched out right arm. In all 72 patients the disturbance of the equilibrium was demonstrated by the caloric test. The subjective insensibility of the patients to the caloric test and the absence of vertigo in nearly all patients is emphasized. Four patients presented loss of the vestibular cross reflex; only 2 of the 72 patients presented spontaneous nystagmus. Hypoesthesia of the trigeminus was observed in 7 patients. Hemifacial paresis was observed in 2, and 2 presented disturbances of the periosteal and tendon reflexes. These symptoms arise from the cerebral trunk, particularly from its bulbar portion. They are characteristic for ulcers and are not associated with other digestive, gastrointestinal, hepatobiliary or pancreatic disturbances. They are not of diagnostic value, but they complete the description of the gastroduodenal ulcer as a condition which still requires clarification.

Treatment of Parotitic Orchitis.—Morin treated 6 men with parotitic orchitis by infiltration of the lumbar sympathetic nerve with 10 to 20 cc. of a 1 per cent solution of procaine hydrochloride. Within three minutes the patients experienced a sensation of heat in the lower extremities at the level of the testicle, which transformed the painful distension into numbness. Within a short time the pain had disappeared completely and permanently in 4 patients. In 2 patients the pain recurred but was attenuated. Distal manifestations, such as headache, thoracic constriction and vomiting, subsided, and the patients were able to sleep. The effect on the temperature is doubtful, since there was a rise of temperature within two to three days after the first infiltration. Defervescence occurred within three days whether or not the patients were treated by infiltration. The size of the testicle decreased, but a temporary increase was observed after infiltration in 1 patient. The course of the orchitis does not seem to be shortened by the treatment. Atrophy of the testicle resulted in 2 of the cases. Infiltration of the sympathetic nerve with procaine hydrochloride is recommended for the alleviation of pain in orchitis.

Wiener klinische Wochenschrift, Vienna

61:161-176 (March 18) 1949. **Partial Index**

Relational Pathology as Basis of Therapeutic Thinking. Commemorating the Death of Gustav Rickers. J. Riese.—p. 161.
*Treatment of Diabetes Insipidus with Strong Analeptics. W. Falta and Hedwig Titze.—p. 164.
Treatment of Local Acute Suppurative Processes with Penicillin. R. Demel.—p. 169.

Analeptics in Diabetes Insipidus.—Falta and Titze report 1 case of diabetes mellitus and diabetes insipidus in a man aged 46. The diabetes mellitus was characterized by the instability of the metabolic condition with variations in the insulin requirement apparently caused by changes in the conditions of excitation in the vegetative centers of the diencephalon. The term "rocker" has been used for this type of a diabetic patient. Irradiation of the area of the hypophysis with roentgen rays caused considerable increase in the excretion of sugar but did not affect the excretion of urine. The diabetes insipidus was characterized by increase in the amount of urine up to 20 liters per day. The hyperexcretion of urine was reduced only temporarily by the implantation of two calf hypophyses into the abdominal skin of the patient. A slight reduction of the amount of urine resulted from the administration of diencephalic narcotics such as monosodium diethylbarbiturate and cyclohexenyl ethyl barbituric acid. Chloral hydrate and pituitrin proved ineffective. The hyperexcretion of urine was reduced to about 7 liters per day by six intravenous injections of 20 cc. of 20 per cent alcohol daily or by 100 cc. of 40 per cent alcohol administered by mouth. Purified vasopressin (tonephin) was the most effective drug in reducing the hyperexcretion of urine, but was not available in sufficient amounts. Desoxyephedrine (pervitin®), 2 to 3 tablets of 0.003 Gm. for two days and 5 tablets for two additional days, reduced the amount of urine to 12 liters per day. This amount of urine was maintained by the administration of 2 tablets of this drug three times for seven days. The amount of urine was reduced to 8 liters within four days by the subcutaneous administration of 0.05 Gm. of phenyl methylamino hydroxy propane (ephetonin®) given three times. Cocaine combined with caffeine exerted a strong antidiuretic effect, but it could not be decided which of the two drugs was responsible for the effect. Two types of diabetes insipidus exist, one resulting from vasopressin deficiency or insufficiency of the supraopticohypophyseal tracts, which may be compensated by the intramuscular or subcutaneous administration of purified vasopressin; the other results from the inhibition of the function of the anatomically normal posterior lobe of the hypophysis, or the normal supraopticohypophyseal tracts by higher centers localized in the thalamus or hypothalamus. This inhibition may be removed by the administration of alcohol or strong analeptics.

V 14
1949

Book Notices

Obstetrics in General Practice. By J. P. Greenhill, B.S., M.D., F.A.C.S., Professor of Gynecology, Cook County Graduate School of Medicine, Chicago. Fourth edition. Cloth. Price, $5.50. Pp. 468, with 108 illustrations. Year Book Publishers, Inc., 304 S. Dearborn St., Chicago 4, 1948.

Four editions of this book have appeared within eight years. By judicious limitation of the subject matter to those aspects of obstetrics which are of direct practical importance, the author has been able to encompass in a volume which is about one quarter the size of our standard textbooks, about all the information which the general practitioner should necessarily possess. Moreover, the common complications are discussed in sufficient detail that he should rarely find it necessary to consult any of the larger works on strictly clinical issues. As a matter of fact, even in those textbooks, he will not often find practical advice provided in greater abundance, or with greater sanity, than in this relatively small manual.

The new edition incorporates all essential new knowledge which is of clinical importance. The section on the troublesome Rh problem has been rewritten and brought up to date. The uses of penicillin and streptomycin in obstetrics, including a detailed consideration of the employment of the former in syphilis, are fully covered. The fifteen page section on placenta previa has been revised in the light of modern trends, and Braxton Hicks version deleted as a recommended method. As in previous editions, safety is emphasized as the paramount objective. The illustrations are attractive and informative, while the small, light format lends itself to easy handling.

General practitioners will find this book full of concise, practical information, and they would do well to read it and take its teachings to heart. If a great many would do so, our maternal and fetal mortality rates would be lower.

The American Academy of Orthopaedic Surgeons Presents Lectures on Regional Orthopaedic Surgery and Fundamental Orthopaedic Problems. Selected from the Instructional Courses of the Thirteenth Annual Assembly, Chicago, January 19-23, 1946. Edited by James E. M. Thomson, M.D., Chairman of the Instructional Section. Cloth. Price, $6. Pp. 249, with illustrations. J. W. Edwards, 300 John St., Ann Arbor, Mich., 1947.

The publication of selected subjects from the 1946 instructional courses on regional orthopedic surgery and fundamental orthopedic problems is of commendable interest to the orthopedic surgeon, the general surgeon and the medical practitioner. The lecturers are all senior orthopedic surgeons of experience and ability.

Among the numerous subjects dealt with, particular emphasis has been placed on the shoulder, hip and foot-ankle region. Excellent papers on the anatomy of the region concerned, which are not too detailed but adequate for the problems considered, open each series. The symptoms, pathology and diagnosis of the frequent causes of disability affecting these large joints are capably and thoroughly discussed. The most comprehensive are those dealing with the shoulder, especially stiffness, pain and moderate injury; and this section is of inestimable value to the young specialist and the general man. It is regrettable that papers dealing with the costoclavicular syndrome and ruptured intervertebral disk lesion of the cervical area have been omitted.

Excellent advice is contained in the section dealing with the principles of fracture management, as well as the problem of the clubfoot. The symposium on degenerative hip disease is comprehensive and instructive. The section dealing with the roentgenologic examination of the spine is timely, considering the tremendous interest that exists in low back pain. Some of the roentgenograms could have been more clear; even lining the vertebral bodies would have increased their usefulness. The two short articles dealing with anterior poliomyelitis are instructive, though one could have wished for additional information on this difficult subject.

The cases presented for discussion, which are included at the end of the book, are excellent, but they could well be made fuller and possibly more cases included in an ensuing year.

The American Academy of Orthopedic Surgeons is to be commended for their successful effort each year in holding an instructional course of such merit as these lectures demonstrate.

Diabetes and Its Treatment. By Joseph H. Barach, M.D., F.A.C.P., Associate Professor of Medicine, University of Pittsburgh, Pittsburgh, Pa. Cloth. Price, $10. Pp. 326, with 73 illustrations. Oxford University Press, 114 5th Ave., New York 11, 1949.

Dr. Barach's medical textbook on diabetes is a newcomer. The author is an experienced clinician and is now chairman of the useful Metabolism and Endocrinology Study Section of the Research Grants Division of the United States Public Health Service. His book is written for the benefit of the medical practitioner who does not see much of the disease. Its style is similar to that used by Dr. Joslin in his well known textbook, especially in that the statistical method of reporting on various phases of the disease is used freely. Barach's own cases ase used in the assembling of these data, for the most part.

The book begins with a review of the history of the accumulation of knowledge about the disease. Descriptions of developments follow one another with little effort on the part of the author to distinguish between major and minor discoveries. The etiologic and incidence background follows the historical section, with statistical summaries predominating.

Chapters on diagnosis, clinical and laboratory, are followed by discussions of "clinical pathology," diseases of the extremities and their treatment, and the use of surgical procedures in the diabetic patient. Diabetic acidosis and coma and pregnancy in the diabetic patient are discussed thoroughly in separate sections. The treatment of acidosis is given in decidedly empiric fashion.

Barach's thorough study of nutrition and growth in childhood are revealed in the extensive data given in the childhood section. Detailed descriptions are given of various factors employed in selection of diet and maintenance of proper nutrition, instruction of the patient and prevention of diabetes by such methods as are available. A chapter on the use of insulin seems inadequate in view of its importance in treatment and the complexities in its use. The final third of the book contains a variety of over three hundred different quantitative diets suitable for every conceivable circumstance, showing in each case the number of grams of food ordered for each meal, their equivalents in ordinary household measures and the fuel values for each meal and totals for the day. These are accompanied by several pages of recipes, conversion tables, tables of caloric values and ideal weights, and instructions for diet calculations.

As the organization of Dr. Barach's book is not very logical, it will serve better as a reference book for practical detail than as one which will train the physician in fundamental understanding. Some of its explanations of mechanisms are scientifically unsound. Its interpretations are those of the practical clinician rather than those of the impartial and well informed physiologist or biochemist. For example, the lower incidence of diabetes in the South, in rural areas and in China is attributed by the author to differences in diet and other conditions of living in these areas, whereas other possible reasons are obvious. The differences could just as well be explained by deficient diagnosis and reporting in these areas, as suggested by Joslin's survey in Arizona.

Other random criticisms are applicable. The discussion of endocrine relationships in diabetes is not well organized and is unconvincing. A good deal of pertinent physiologic evidence is omitted. The author's instructions that insulin should be omitted or reduced in illness or prior to operation seem dangerous. The author's tolerance for higher sugar levels in mild diabetes is out of line with modern views that much is to be gained by good control in patients who are so easy to manage. The arbitrary prescription, oft repeated, of 1 unit of insulin for every 2 Gm. of glucose in the urine or diet fails to allow for sharp individual variations in insulin sensitivity. The decisive value of insulins with intermediate action and their use in practice is not sufficiently appreciated or covered in a book written in 1949.

This book might be described succinctly as a useful encyclopedia of empiric information regarding diabetes, written in a simple, uncritical style, with moderate views which attempt to compromise in controversial matters, sometimes at the expense of clarity and accuracy.

Surgical Technique and Principles of Operative Surgery. By A. V. Partipilo, M.D., F.A.C.S., Associate Clinical Professor of Surgery, the Stritch School of Medicine of Loyola University, Chicago. Foreword by Alton Ochsner, M.D., F.A.C.S., William Henderson, Professor and Director of the Department of Surgery, The Tulane University School of Medicine, New Orleans. Original illustrations by W. C. Shepard and Hooker Goodwin. Fourth edition. Cloth. Price, $15. Pp. 676, with 541 illustrations. Lea & Febiger, 600 S. Washington Sq., Philadelphia 6, 1949.

Although the previous editions of this work were considered excellent, this edition is an improvement over the others. Most of the book is the work of the author, but a number of excellent chapters were contributed by collaborators who are practicing surgeons of wide experience and actively engaged in teaching. The book covers the surgery of hernia, stomach and intestines, gallbladder, duodenum, pancreas, colon and rectum, breast, thyroid, peripheral vascular diseases and facial injuries. Several chapters are devoted to the general principles of surgery, including a historical review of the sciences of physiology, pathology and anatomy, and the value of these to the surgeon; a discussion of incisions, hemostasis and wound healing. Various methods of knot tying are described and illustrated minutely. The newer surgical procedures, such as vagus resection, surgery of the pancreas, colon and rectum, biliary tract, heart and peripheral vascular system are included and discussed in detail.

Where indicated, each chapter includes a review of surgical anatomy and a discussion of pertinent pathologic and physiologic aspects of each subject. The importance of diagnosis, indication for operation and preoperative and postoperative treatment is emphasized. Technical steps of each operative procedure are described in detail and profusely illustrated. The significance of atraumatic technic, careful hemostasis and gentle handling of tissues, which are essential in any operative procedure, is particularly stressed.

The book is well written. It is clear and concise. The material is up to date, practical and logically presented. The illustrations are numerous and of excellent quality. They combine anatomic and technical detail with scientific accuracy, and greatly enhance the value of the text.

The book is a distinct addition to the library of every student and practitioner of medicine.

Recent Advances in Respiratory Tuberculosis. By Frederick Heaf, M.A., M.D., F.R.C.P., Senior Medical Officer, London County Council, and N. Lloyd Rusby, M.A., D.M., F.R.C.P., Assistant Physician, The London Hospital, London, England. Fourth edition. Cloth. Price, $5.50; 21 s. Pp. 290, with illustrations. The Blakiston Company, 1012 Walnut St., Philadelphia 5; J. & A. Churchill, Ltd., 104 Gloucester Place, Portman Sq., London, W.1, 1948.

This book is a revision of a book under the authorship of L. S. T. Burrell of London, who was the author of the first three editions. The present authors prepared the fourth edition in order to describe the notable advances in respiratory tuberculosis since the previous author's death. They feel that the outstanding single development in the management of tuberculosis in the last decade has been realization of the important part which environment and social circumstances play in the successful control of tuberculosis.

There are several excellent chapters on the subject of resistance and infection. Much of the material presented is quoted from many reliable sources from various countries.

The present conception of the value of BCG in immunization of whole populations is discussed. The authors feel that the ideal protection has not been found but that statistical studies warrant the belief that attenuated tubercle bacilli must be nonvirulent, as injection of virulent tubercle bacilli is too risky. The statistical studies presented do not seem to warrant the assumption that BCG is a virulent form of the tubercle bacilli.

Mass radiography has been the most modern innovation in the campaign against tuberculosis. This statement is shared by tuberculosis specialists throughout the world. Considerable attention is given to the technic of roentgen ray studies, and one sentence in the discussion of this subject warrants repetition: "Progressive improvements in apparatus have increased the simplicity of operation, but no x-ray plant can eliminate errors due to wrong positioning, dusty screens, incorrect penetration, bad developing. . . ." Tomography is discussed, and the authors suggest that no well regulated hospital or sanatorium should be without a tomograph. Attention is given to the anxiety states of the tuberculous in relation to symptoms, and the authors suggest that complete physical and roentgen ray studies should be made in all cases to establish the exact state of the lungs.

A significant discussion is presented on the relationship of tuberculosis and pregnancy, and from much quoted material from various countries the authors suggest that termination of pregnancy is not necessary in well controlled cases of tuberculosis in sanatoriums. Collapse therapy is urged in all cases of tuberculosis where pregnancy is present.

Nearly all the new surgical procedures for collapse and relaxation of the lung are described rather briefly; much more space is given to pneumothorax. Lobectomy and pneumonectomy are also mentioned. The authors state that there is a place for such radical surgery in only a few cases.

Socialized medicine from the British point of view is described in several chapters at the end of the book. The government has innumerable rules and regulations to cover diagnosis, treatment and the length of stay in the hospital or sanatorium. This type of control would certainly not appeal to American tuberculosis specialists. The British government also gives a minimal living expense to the family while the breadwinner is under treatment. There are only six reproductions of roentgenograms in the book.

This work is a good review of the present conception of tuberculosis and also of the present mode of treatment, and is recommended to students, public health nurses and general practitioners.

Recent Progress in Hormone Research: The Proceedings of the Laurentian Hormone Conference (1947). Volume III. Edited by Gregory Pincus. Cloth. Price, $7.80. Pp. 378, with illustrations. Academic Press, Inc., 125 E. 23rd St., New York 10, 1948.

Dr. Gregory Pincus has again performed a masterly task in assembling and editing the proceedings of the Laurentian Hormone Conference. As in previous conferences, the emphasis was on the chemistry and physiologic actions of the various steroid hormones and their derivatives. An excellent discussion of the relation of the doisynolic acids to the various sex hormones is presented by Dr. K. Miescher. Only recently have chemical methods been available for a complete study of the relationship of these acids to the naturally occurring sex steroids.

Drs. Seymour Lieberman and Konrad Dobriner present a highly technical, but nonetheless interesting, discussion of steroid excretion in health and disease. The difficulties encountered in attempting quantitative studies of steroid excretion appear to be diminishing; Dr. Dobriner's group is making great strides in elucidating the alterations in the pattern of steroid excretion in various metabolic and endocrine disorders. A presentation by Dr. Harold L. Mason on the metabolism of adrenal hormones extends the paper of Drs. Lieberman and Dobriner into a field which is of rapidly growing importance.

Two papers on chemical cytology by Dr. Edward W. Dempsey and by Dr. C. P. Leblond summarize the progress made in this area, in which the chemist and the pathologist join hands in an attempt to unlock the mysteries of intracellular metabolism.

The biochemistry of the growth hormone is discussed by Dr. Choh Hao Li and Dr. Herbert M. Evans, the former having produced the first pure preparation and the latter having discovered this pituitary hormone.

The physiology of the testis is discussed in four papers, and, as usual, a great deal of the discussion centers around hypogonadism and the "male climacteric." The papers by Dr. Warren O. Nelson and Dr. Carl G. Heller and by Dr. James B. Hamilton serve to clarify this field, which has been well discussed in previous conferences.

For the first time, the relationship of hormones to hypertension receives exhaustive discussion. The relationship of the renal pressor system to humoral influences is presented by Dr. A. C. Corcoran. The relationship of renin, angiotonin and the various enzyme systems with specificity for these substances to other pressor systems within the body is reviewed. Dr. Hans Selye discusses hypertension as a disease of adaptation, a point of view gaining adherence by an increasing number of workers in this field.

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Of great value to the student of endocrinology are the delightful and informative discussions given at the end of each paper. The excellent editing of these discussions preserves their informality but makes them a valuable addition to the formal text.

The proceedings of these conferences, of which this is the third volume, should be in the library of every person seriously interested in the fundamental aspects of endocrinology.

Lehrbuch der Geburtshilfe. Von Prof. Dr. med. Heinrich Martius, Direktor der Universitäts-Frauenklinik Göttingen. Unter Mitarbeit von Professor Dr. med. Werner Bickenbach, Professor Dr. med. Kurt Nordmeyer und Käthe Droysenals Zeichnerin. Erster Teil: Physiologie Zweiter Teil: Pathologie. [Reprint of 1943 edition]. Boards. Pp. 568; 569-1176, with 1025 illustrations. Georg Thieme, Diemershaldenstrasse 47; Stuttgart-O, 1948.

In the first volume of the *Lehrbuch* the author takes up the physiology of pregnancy, labor, the puerperium and lactation, multiple births, the healthy newborn infant, prenatal care and nutrition of the mother. In the second volume he discusses the pathology of pregnancy, dystocia in labor, the pathology of the puerperium and diseases of the newborn. There are 539 illustrations in the first volume and 486 in the second. Many illustrations are in color and nearly all of them are clear and instructive. However, the reproductions of the roentgenograms are poor. Several illustrations could have been omitted without detriment to the book. The Crede maneuver for separation and delivery of the placenta should not be described or illustrated because, as the author himself admits, the maneuver can do harm. Likewise, the illustrations devoted to packing the uterus for the control of postpartum hemorrhage should be deleted because uterine tamponade has wisely been given up by most obstetricians. The author should omit from the next edition the illustrations of the Gylicki and Gauss pelvimeters for measuring the pelvic inlet because this procedure is not only painful but is entirely unreliable. These instruments should be relegated to the past with the many similar instruments once considered useful. There is no point in demonstrating a colored photomicrograph of a kidney from a woman who died of eclampsia because this lesion is not pathognomonic of eclampsia. In several of the illustrations, ungloved hands are shown, as for packing the uterus. The reviewer disagrees with the author that chloroform is the best anesthetic to use in eclampsia. The safest anesthetic is direct infiltration and the next safest is low spinal.

In spite of these criticisms, the book is excellent. Throughout both volumes, it is apparent that the author has had extensive experience in clinical obstetrics. The advice given is conservative and to the point. Assistance was given by Werner Bickenbach and Kurt Nordmeyer, and the illustrations were drawn by Kaethe Droysen. All these as well as the publishers are to be commended for having produced a good book.

Practical Spectroscopy. By George R. Harrison, Ph.D., Sc.D., Professor of Physics; Richard C. Lord, Ph.D., Associate Professor of Chemistry, and John R. Loofbourow, Sc.D., Professor of Biophysics, of the Spectroscopy Laboratory, Massachusetts Institute of Technology, Cambridge, Massachusetts. Cloth. Price, $6.65. Pp. 605, with illustrations. Prentice-Hall, Inc., 70 Fifth Ave., New York 11, 1948.

The authors have presented a comprehensive discussion of the status and possibilities of experimental spectroscopy as it exists today. This includes applications in the fields of physics, chemistry and biology. Emission spectroscopy is treated in detail, including discussions of equipment, facilities and technics. Several methods, such as fractional distillation and the moving plate method especially applicable to the examination of biologic mixtures, are discussed. Absorption spectrophotometry in the ultraviolet, visible and infra-red regions is discussed in less detail. However, these sections constitute one of the best presentations on this field available today in book form. Currently, there is a great increase in the use of spectrophotometry in clinics and pharmacology laboratories. The chapters relating to this subject are recommended reading for all connected with such laboratories.

In discussing a field so widespread as spectroscopy, it is impossible to present an exhaustive description of each technic. An extensive bibliography is given, so that references to more detailed discussions are almost always presented.

Athletic Injuries: Prevention, Diagnosis and Treatment. By Augustus Thorndike, M.D., Chief Surgeon to the Department of Hygiene, and to the Harvard Athletic Association, Harvard University, Cambridge, Massachusetts. Third edition. Fabrikoid. Price, $3.75. Pp. 243, with 114 illustrations. Lea & Febiger, 600 S. Washington Sq., Philadelphia 6, 1948.

This book is well written and well edited. There is one error in the transposition of titles in figures 80 and 81 which is obvious and a typographical error in spelling on page 210. The book gives a clear, concise picture of the diagnosis and treatment of athletic injuries at Harvard University.

Two chapters on "Physical Fitness" and "Physical Fatigue" give sound scientific discourses on these subjects. The author claims that there is no such thing as "the athletic heart." He advocates a break in the monotonous routine of daily practice in order to obviate "mental fatigue."

The author believes that the prevention of injuries is important. This is done by special exercises for the knee and shoulder joints, as well as for other muscles and joints. A sprained ankle always remains a weakened joint, he claims, but he does not believe in routine strapping of ankle joints. "Once a sprain always a sprain."

The protective pads and covering should be regulated uniformly so that they will not injure opposing players.

Thorndike then takes up the different injuries individually in chapters headed "Sprains," "Strains," "Contusions," "Fractures and Dislocations," "Internal Injuries," etc. He lays stress on the early use of cold for many. His statistics compare favorably with those of Lloyd, Deaver and Eastwood and of Hobart, and the knee again leads all other parts of the body in number and percentage of injuries. He lays great stress on muscle injuries, which other authors do not find so frequent or serious.

In mentioning knees the author emphasizes a careful examination. Over half of his knee injuries were sprains, and he claims that he has had only six internal derangements (meniscus damage) in 423 cases since using the Duke-Simpson strapping. This ingenious but complicated strapping is employed in all athletes with a history of earlier sprain. In fifteen years' experience among 16,000 athletes only thirty-three semilunar cartilage injuries were found, necessitating only six operations. However, he does recognize what he calls "inherited school boy knee" and refuses such persons the privilege of playing football. Many of these injuries can be cured by operation and exercises.

The Achievements of BCG Vaccination, Illustrated by Material at the Tuberculosis Department of the Oslo Public Health Service. By Gerhard Heitzberg, Medical Officer. Paper. Price, 15 Norwegian kroner. Pp. 312. Johan Grundt Tanum-Forlag, Kr. Augustsgate 7a, Oslo, 1948.

This report of a study of the results of BCG vaccination was culled from the records of the Tuberculosis Department of the Oslo Public Health Service. Of 18,496 persons vaccinated, only a portion were available for analysis. Matched with the vaccinated were 1,832 nonvaccinated persons, who served as controls.

The Norwegian law of 1942 made convertors (persons whose tuberculin skin reactions changed from negative to positive) reportable. In December 1947, BCG was made compulsory for certain groups in Norway. In this material BCG seemed to eliminate such primary tuberculous lesions as erythema nodosum and tuberculosum, hilar adenitis and roentgenologic primary foci in the lungs. This seemed to be more evident in males than in females.

A comparison of the vaccinated and the controls revealed a difference in the rate in the two groups, as follows: group A, true primary tuberculosis of the lungs and hilar lymph nodes, with or without skin manifestations, 1 to 137; group B, tuberculosis of glands, skin and soft tissues, 1 to 6; group C, pleuritis, pulmonary infiltration, and tuberculosis of the bones, joints and eyes, 1 to 9, and group D, tuberculous meningitis, miliary tuberculosis and destructive pulmonary tuberculosis, 1 to 27.

For all forms of tuberculosis, the difference in the rate between the vaccinated and the controls was 1 to 23. The difference in death rate from tuberculosis was 1 to 45. The author states, "The value of such rates will be very limited from the statistical point of view, but they bring out points of considerable interest."

Evidence is presented that the local reaction following vaccination determines to a great extent the subsequent tuberculin reaction. The degree of the tuberculin reaction determines the duration of the vaccination allergy, but is not related to resistance on superinfection.

Reinfection tuberculosis is considered in persons in whom the von Pirquet reaction increases at least 2 mm. and in whom the Mantoux test with 1 mg. of old tuberculin increases by 20 mm. The validity of these criteria for reinfection will not be argued, but since they represent but a small fraction of the actual state of reinfection, the use of these observations may be misleading.

In a study of some 900 cases by the reviewer, three physicians read the tuberculin reactions in control and vaccinated children up to 18 years of age. There was no notable difference in the type of reactions of the two groups.

The author prefers the intradermal to the multiple puncture method, his comparison being made on 1,749 persons vaccinated by the intracutaneous method against 51 by the multiple puncture method. This would hardly seem a fair comparison, especially since the author states, "I have no proof that the other factors mentioned (contact with tuberculosis, etc.) are uniformly distributed in the two groups."

The data presented are unequivocal concerning the harmlessness of BCG vaccination. The evidence is most impressive regarding the efficacy of BCG vaccination, both in regard to morbidity and mortality from tuberculosis. Both physicians and statisticians will find this book of great interest.

Modern Trends in Psychological Medicine, 1948. Edited by Noel G. Harris, M.D., F.R.C.P., D.P.M., Physician for Psychological Medicine, Middlesex Hospital, London. Cloth. Price, $10. Pp. 450, with 25 illustrations. Paul B. Hoeber, Inc., Medical Book Department of Harper & Brothers, 49 E. 33d St., New York 16, 1948.

In nineteen comprehensive chapters here is a presentation of the present status of psychiatry and what we may expect of it. The editor and the several authors are outstanding. Only one chapter deals with a nosologic group; that one is on psychopathic personality, and it leaves something to be desired in its failure to recognize some of the psychodynamic contributions of Karpman and Maughs, for instance. The other chapters deal with psychosomatic medicine, the physiology of emotions, causative factors in mental disturbances, electrophysiology, diagnostic measures, child guidance, marriage and family life, group therapy, psychotherapy, physical treatment, personnel selection, rehabilitation, mental hygiene in industry and the relation of psychiatric medicine to world affairs. The approach throughout is broad; the doctrinaire attitude is conspicuous by its absence.

The chapters are carefully prepared, and each is followed by a bibliography. The printing is excellent, and there are twenty-five illustrations. The volume is an excellent presentation of the present state and prospects of a specialty which is developing rapidly.

Fractures and Orthopaedic Surgery for Nurses and Masseuses. By Arthur Naylor, Ch.M., M.B., M.Sc., Orthopaedic Surgeon, Bradford Municipal General (St. Luke's) Hospital, Bradford, England. Foreword by Ernest Finch, M.D., M.S., F.R.C.S., Consulting Surgeon, Royal Infirmary and Hospital, Sheffield, England. Second edition. Cloth. Price, $5. Pp. 296, with 251 illustrations. The Williams & Wilkins Co., Mt. Royal & Guilford Aves., Baltimore 2, 1948.

It is to help nurses and masseuses to understand and follow the principles of orthopedics that Mr. Naylor has written this book. He shows the nurse how the principles are applied in orthopedic surgery and as a supplement to her lectures in surgery. The introduction of penicillin has necessitated alterations in the text of this, the second edition.

The success of orthopedic surgery is largely dependent on the knowledge, skill and care of the nurses and physical therapists to whom after-care and treatment are delegated. The student nurse has often only a bare minimum of instruction in orthopedic surgery; yet approximately one fifth of her surgical work will be concerned with this branch of surgery.

This book will be useful to registered nurses and to those who intend to undertake or are engaged in nursing in orthopedic wards, or at special hospitals or in the public health services. It should be of value to physical therapists as a general outline of the clinical and surgical aspects of orthopedic conditions.

The author discusses orthopedic apparatus; operating room technic; methods of correction of deformity; amputations; fractures and dislocations; diseases of bones and joints, diseases of the soft tissues; congenital deformities; diseases of the epiphyses; peripheral vascular lesions; orthopedic surgery of paralysis, and diseases of the spine and foot.

Poisons: Their Isolation and Identification. By Frank Banford, B.Sc. Revised by C. P. Stewart, M.Sc., Ph.D., Senior Biochemist, Royal Infirmary, Edinburgh. With a foreword by Professor Sydney Smith, C. B. E., M.D., F.R.C.P., Regius Professor of Forensic Medicine, University of Edinburgh, Edinburgh. Second edition. Cloth. Price, $5. Pp. 304, with 23 illustrations. The Blakiston Co., 1012 Walnut St., Philadelphia 5, 1947.

The book is offered as a practical guide for the chemical analysis of various poisons. As a laboratory manual for the qualitative analysis of these poisons, it goes into much detail with respect to technic and appears to be written from first hand experience.

The poisons are classified into various groups which are determined by the methods used for their isolation and separation. The author devotes a chapter or two to the discussion of each group and the poisons it contains. The groups are the volatile poisons—that is, those which distil with a current of steam—the metallic poisons, the acid, alkali or irritating salt type, the nonvolatile basic organic poisons, the nonvolatile nonbasic organic poisons and a miscellaneous group which require various special methods for isolation.

A systematic scheme is presented for the identification of alkaloids which is based on their reaction with various precipitation and color reagents. A chapter is also devoted to a systematic procedure for the separation and identification of various nonbasic organic poisons.

The book, although intended as a laboratory manual, is written in a style which makes for easy and interesting reading. It contains numerous helps and suggestions for the practicing toxicologist, such as a brief outline of postmortem signs, as indications of the cause of poisoning.

Nutrition and Physical Fitness. By L. Jean Bogert, Ph.D., Instructor in Experimental Medicine, Yale Medical School, New Haven, Conn. Fifth edition. Cloth. Price, $4.25. Pp. 610, with 97 illustrations. W. B. Saunders Company, 218 W. Washington Sq., Philadelphia 5; 7 Grape St., Shaftesbury Ave., London W.C. 2, 1949.

The author states that the purpose of this book is threefold: (1) to gather into a single volume information useful in meeting everyday nutritional problems, which has been gleaned from the fields of food composition and economics, the chemistry and physiology of body processes, dietetics and medicine; (2) to make this information available to a comparatively large group by presenting it in such simple language as to be understandable to those with no previous knowledge of chemistry, and (3) to point out, in every instance possible, how such knowledge may be utilized for preventing ill health and promoting a high degree of physical fitness.

Part I includes a discussion of sugars, starches, proteins, fats, milk and milk products, fruits and vegetables. The different varieties of these food groups, their chemical properties and their place in the diet are presented in detail.

Part II is concerned with the nutritional needs of the body. There seems to be some burdensome repetition between these two sections. For example, in part I complete and incomplete proteins are elaborated on at some length. This is repeated in part II. The book might seem better organized if the order of these two sections were reversed.

In the text tables are included which give the approximate ascorbic acid, thiamine and vitamin A content of typical foods in terms of average servings. To be consistent, it would be logical to prepare similar tables for the other important nutrients. This type of information is more practical than tables of percentage composition.

Part III is a section on physiology, dealing chiefly with digestion, metabolism and excretion. Part IV contains helpful facts about meal planning, food economics, food fads and fancies, and recent trends in our dietary habits. The last chapters are on diet for special conditions such as obesity, underweight and pregnancy. The dietary needs during childhood are also presented. The appendix includes a table of food values, tables of ideal heights and weights for adults and children and a list of

100-calory portions of common foods, which material is becoming less popular with nutritionists because it is impractical to use in teaching.

Each chapter concludes with questions and problems for classwork and lists of suggested readings. The textbook can be recommended for use in teaching a college course in nutrition or as a reference book for a course in nutrition for nurses, social workers or teachers. High school teachers of biology or health education would also find practical information in it suitable for integration in their classwork.

Symposium on Radioiodine July 28-30, 1948. Brookhaven Conference Report, BNL-C-5. Paper. Price, $1.50. Pp. 114, with 27 illustrations. Brookhaven National Laboratory, Associated Universities, Inc., Upton, L. I., N. Y., [n.d.]

The volume opens with a historical review of the use of iodine in the treatment of diseases of the thyroid and moves rapidly to modern times and the first use of I^{131}. The remainder of the volume is divided into sections. These sections correspond to the various component sessions of the symposium.

The first session was on physiology and was opened with an interesting paper on I^{131} as a tracer in thyroid neoplasm. A paper of note in the physiology section is the mechanism of action of antithyroid drugs. In another paper the biologic effect of radiation by radioactive iodine is well considered. The second session was a session on laboratory topics. Several papers of considerable merit are contained herein, notably one on standardization of radioactive iodine and another on calculation of dosage in radioiodine therapy. The third portion of the volume is devoted to the proceedings of the session on hyperthyroidism. In this section most of the progress in the treatment of hyperthyroidism and toxic goiter by I^{131} is outlined. The fourth section of the volume is devoted to pathology and allied topics. Outstanding in this section are papers on histologic types of thyroid carcinoma and their respective abilities to store radioactive I^{131}. Several technics of radioautography are outlined in this section and are well worth consulting.

The final section of the volume is devoted to a study of the treatment of carcinoma of the thyroid. In the two papers that comprise this section there are outlined several methods of enhancing the uptake of I^{131} by metastatic thyroid neoplasm.

The volume should be read by everyone who works with radioactive materials, but it could also be consulted profitably by any practicing physician.

Collateral Circulation (Anatomical Aspects). By Daniel P. Quiring, Ph.D., Head of the Anatomy Division, Cleveland Clinic Foundation, Cleveland, Ohio. Cloth. Price, $5. Pp. 142, with 61 illustrations, 46 in color by Margaret Holman. Lea & Febiger, 600 S. Washington Sq., Philadelphia 6, 1949.

The author offers a convenient reference book to the chief arterial and venous collateral channels of the human body. Although a brief review is given of the major circulatory pathways as found in standard anatomic textbooks, emphasis is placed on the communicating shunts as demonstrated in original dissections and as gleaned from the literature. The author has correlated in a refreshing, simple fashion material drawn from anatomic, physiologic and clinical sources as it relates to the problem of blood circulation. As such the study should hold wide interest. Easily accessible are the chief cross connections which develop in the vascular system on occlusion of vessels normally responsible for the circulation to a body part. A short historical review is followed by a lengthier note on the development of blood vessels. Embryology and comparative anatomy are drawn on and the author concludes that inheritance and hemodynamic forces incident to blood flow determine the pattern of the vascular tree. Blood goes where it is needed.

A philosophic discussion of the development of collateral pathways follows. Of clinical interest particularly is the differentiation of changes incident to sudden and gradual occlusion of main stems. In the latter situation the collateral circulation depends primarily on the state of the walls of the anastomosing channels and in lesser degree on their number and their diameter, while in sudden occlusion the primary factors are the number and extent of the anastomoses, secondarily the nature of the walls.

The simplified line color diagrams with which the book abounds are of great help in portraying the three dimensional effect incident to these cross connections. This is true in depicting the four major collateral pathways through which blood is returned to the heart from the lower extremities and trunk. Color drawings on skeletal relief are used effectively to demonstrate the by-passes found in head and neck, trunk, shoulder and upper extremity, and lower extremity. A separate section is devoted to cardiac circulation. Of particular merit is the discussion relative to collateral pathways about the carotid arteries, adrenal vessels, vena cava, leg veins, and the important vertebral veins. The integration of this knowledge finds clinical application in understanding the fate of parts following vascular accidents, the dispersion of infections and the metastases of cancer.

This enlightening emphasis on collateral channels warrants attention from the anatomist and physiologist in understanding the basic pattern and function of this circulation, and should be of value to the clinician in the practical application of this knowledge.

Principles of Health Education Applied. By Clifford Lee Brownell, Ph.D., Chairman, Health Education and Physical Education Department, Teachers College, Columbia University, New York, N. Y. McGraw-Hill Series in Health Education, Physical Education, and Recreation. Clifford Lee Brownell, Consulting Editor. Cloth. Price, $3.75. Pp. 366, with 16 illustrations. McGraw-Hill Book Company, Inc., 330 W. 42d St., New York 18; Aldwych House, Aldwych, London, W.C. 2, 1949.

Inaugurating a new series in health education, physical education and recreation, this volume is addressed specifically to students of health education and generally to all those with a participating interest in this subject. These, of course, range from teachers through administrative officers to parents and the general public that foots the educational bill.

In most part, Brownell does an excellent job of presenting both sides of the numerous highly debatable phases of health education. However, there is some evidence that there has been insufficient collaboration with the medical profession on some phases of the volume. Specifically, Brownell accepts without reservation the spurious claims based on prejudiced or even deliberately false analyses of World War II draft statistics, and in the face of evidence such as that presented by Freedman or in the Brookings report he writes on page 31 of the "appalling number of young men found unfit for military service" and on page 274 offers a quotation emphasizing the same serious misunderstanding. Although Brownell does offer a rationalization of this situation on page 32, it is considerably less emphatic than his "pro" discussion.

After four chapters of orientation on the general problem of health and health education, the book treats specific subjects such as school organizations for health, health services, education of the handicapped, health and safety instruction and professional preparation for health education. Understandably, there is a strong chapter on the relationships between health education and physical education. This contains adequate recognition of the necessity for proper medical supervision of physical education activities.

Perhaps the only serious omission in the volume is consideration of sex education in relation to health education.

The book is written in a friendly style, and of special value are summaries at the end of each chapter plus lists of questions and problems for discussion as well as selected references. Physicians will find it of interest as a source of helpful background for their contacts with medical aspects of school health education and services.

Hypnotism Comes of Age: Its Progress from Mesmer to Psychoanalysis. By Bernard Wolfe and Raymond Rosenthal. Cloth. Price, $3. Pp. 272. The Bobbs-Merrill Co., 724-730 N. Meridian St., Indianapolis 7, 1948.

With the development of hypnonarcosis as an establis'ed technic by investigations of psychiatric disturbances during the war, much interest has been aroused in the method. The volume here considered approaches the subject from the special point of view of the psychoanalyst and indicates the manner in which the two technics can be integrated for application. One of the best chapters is entitled "The Layman Asks Some Questions"; this does give authentic replies to most of the questions that arise in the minds of average readers.

Krebsmetastasen. Von Dr. med. Hans E. Walther, leitender Arzt der Röntgenabteilung des Schwesternhauses vom roten Kreuz in Zürich. Vorwort von Prof. Dr. H. von Meyenburg, Direktor des Pathologischen Institutes in Zürich. Cloth. Price, 60 Swiss francs; $18. Pp. 560, with 359 illustrations. Benno Schwabe & Co., Klosterberg 27, Basel 10; Imported by Grune & Stratton, Inc., 381 Fourth Ave., New York 16, 1948.

The physician's interest in patients with cancer frequently diminishes in proportion to the spread of cancer from its original site to other organs, because medicine or surgery offers little to relieve metastatic cancer and radiation therapy is at best only palliative. Neoplastic metastases, therefore, are seldom the subject of intensive scientific study.

This book, written in German by a Swiss radiologist, attempts to fill this gap in the medical literature and is based on many years of clinical experience and extensive study of pathologic-anatomic material. Postmortem examinations on 3,433 patients with cancer form the basis for the author's thoughtful monograph. An attempt is made to uncover guiding principles which govern the spread of cancer and thus to facilitate the evaluation of the prognosis in different types of malignant growths.

The book is divided into two main parts. In the general section, the morphologic and biologic qualities of the cancer cells and the grading of malignancies are explained and the author's "malignancy index" described. The latter is determined by adding the continuous extension (c) of the tumor, its lymphatic spread (l) and its hematogenous (h) spread, all of which are arbitrarily evaluated in a relation of 1:2:10 and divided by 100. Therefore, the formula of the "malignancy index" is as follows:

$$M = \frac{c + 2l + 10h}{100}$$

According to the author, the occurrence of metastases follows closely the anatomic design of the blood vascular system and can be predicted if the primary site is known. Conversely, if neoplastic metastases are found in various organs, the site of the primary lesion can usually be assumed with a high degree of certainty. The author is convinced that all metastases to lymph nodes are "regional." They are either "primary," if they are localized in the draining area of the primary tumor, or "secondary," if the tributary organ is invaded by way of the blood system. The author does not accept the theory of lymphatic connections between two different organs. The possibility of "retrograde" lymphatic spread is refuted by the author, and so this controversy is continued. The chapter on diagnostic methods of neoplastic metastases is short, and cytologic methods are discussed. The Papanicolaou stain, chiefly important for the diagnosis of primary lesions, is not mentioned.

In the special section, the frequency of different types of malignant growths in the various organs is described, and growth tendencies and modes of spread analyzed. Statistical evaluations support the author's theories.

The book is well written and offers a wealth of material for thought. It is a fascinating piece of work by an earnest and experienced clinician who expresses his ideas in a convincing manner. Minor differences of opinion as to the frequency of metastases in different organs do not depreciate the value of a readable and highly recommendable work.

Morfologiczne badania porównawcze nad rolą układu mezenchymalnego a w szczególności sercowo-naczyniowego w zapaleniu hiperergicznym i gośćcowym. [By] Kazimierz Stojałowski. [Comparative Morphologic Studies on Role of Mesenchymal System and Especially of Cardiovascular System, on Hyperergic and Rheumatic Inflammation.] Poznańskie Towarzystwo Przyjaciół Nauk. Prace Komisji Lekarskiej Tom VI, Zeszyt 1. Paper. Pp. 159, with 15 illustrations. Poznańskie Towarzystwo Przyjaciół Nauk, ul. Sew. Mielżyńskiego 26/27, Posen, 1947.

This monograph deals with the author's microscopic studies of postmortem material of the Pathologic Institute of the University of Poznań (Poland). An attempt is made to bring into correlation the microscopic alterations in rheumatic fever as regards the connective tissue and the circulatory system, and the analogy between rheumatic fever and experimental hyperergic inflammation. Experiments performed by the author represent a modification of Klinge's experiments. The modification consisted in sensitizing rabbits by human rather than horse serum. Serum obtained from a case of acute rheumatic fever and from a case of asthma was injected into the knee joint of a sensitized rabbit. A striking resemblance was noted in the histopathologic alterations in experimental hyperergic inflammation and in those of the rheumatic fever. The distribution of the lesions throughout the mesenchymal system was much the same in both conditions. The author concludes that the lesions in the mesenchymal system seen in rheumatic fever can only be explained on the basis of alterations in its immunobiologic reaction; that therefore the basis of rheumatic fever is a hyperergic mechanism.

The concept is not new. The work does not represent anything very original or significant. It should, however, be of some interest to the pathologist and the internist.

Practical Methods in Biochemistry. By Frederick C. Koch, Director of Biochemical Research, Armour & Co., Chicago, and Martin E. Hanke, Associate Professor of Biochemistry, University of Chicago, Chicago. Fifth edition. Cloth. Price, $3. Pp. 419, with 22 illustrations. William Wood & Co., Mount Royal and Guilford Aves., Baltimore 2, 1948.

The present edition of this laboratory manual has kept abreast of new developments by including technics recently developed in biochemistry. The material in the book has been expanded by a greater elaboration of manometric methods, the inclusion of microbiologic procedures for vitamins and amino acids and the incorporation of new or revised colorimetric and fluorometric methods.

The manual is intended to present to medical students qualitative and quantitative methods of analysis used on cell constituents and body fluids. The experiments are classified into sections concerning The Chemistry of Cell Constituents, The Chemistry of the Digestive Tract, and Blood and Urine. The appendix includes instructions for preparing the reagents and solutions used. The experiments are clearly described in detail.

Undoubtedly, this is one of the better small books available for its intended purpose in this field.

Subacute Bacterial Endocarditis. By Emanuel Libman, M.D., and Charles K. Friedberg, M.D., Adjunct Physician, The Mount Sinai Hospital, New York. Edited by Henry A. Christian, A.M., M.D., LL.D. [Reprinted from Oxford Loose-Leaf Medicine with the same page numbers as in that work.] Second edition. Cloth. Price, $3.50. Pp. 346(1)-346(113), with 19 illustrations. Oxford University Press, 114 Fifth Ave., New York 11, 1948.

Dr. Friedberg has fully revised this valuable volume, the earlier result of a lifetime of study of bacterial endocarditis by the late Dr. Libman. The advent of a satisfactory therapy has necessitated emphasis on early diagnosis and treatment. The necessity for a bacterial diagnosis is emphasized by the fact that organisms not susceptible to penicillin may be treated with streptomycin or other more recent antibiotics. This is an excellent study of bacterial endocarditis and almost necessary for those not fully familiar with the subject who may occasionally treat this disease.

Organic Chemistry with Applications to Pharmacy and Medicine. By Eldin V. Lynn, Ph.D., Professor of Chemistry, Massachusetts College of Pharmacy, Boston. Third edition. Fabrikoid. Price, $5. Pp. 355. Lea and Febiger, 600 S. Washington Square, Philadelphia 6, 1948.

This book was written to serve as a textbook for the teaching of organic chemistry to students of pharmacy and medicine. In general, it is organized as are most textbooks of organic chemistry, treating the aliphatic hydrocarbons and their substitution products in the first chapters, followed by material on the aromatic hydrocarbons and their substitution products. Several chapters are devoted to the condensed nuclei and the various heterocyclic systems and a number of chapters deal with such special topics as alkaloids, proteins, enzymes, glycosides and resins.

Each of the chapters has a general introduction dealing with nomenclature and the general physical properties of the class involved, followed by sections on the preparation of the members of the class and the various group reactions. The unique feature of the textbook is that portion of each chapter which treats the chemistry of compounds found in the United States Pharmacopoeia, the National Formulary and New and Non-official Remedies.

The discussions of the subjects are rather brief and are almost outline in form; however, most of the fundamental reactions and general principles are presented. The third revision was written to include the more recent advances in drug therapy as found in the last editions of U.S.P., N.F. and N.N.R.

V 14 1949

Queries and Minor Notes

THE ANSWERS HERE PUBLISHED HAVE BEEN PREPARED BY COMPETENT AUTHORITIES. THEY DO NOT, HOWEVER, REPRESENT THE OPINIONS OF ANY OFFICIAL BODIES UNLESS SPECIFICALLY STATED IN THE REPLY. ANONYMOUS COMMUNICATIONS AND QUERIES ON POSTAL CARDS WILL NOT BE NOTICED. EVERY LETTER MUST CONTAIN THE WRITER'S NAME AND ADDRESS, BUT THESE WILL BE OMITTED ON REQUEST.

DEFERMENT OF CHILDBEARING

To the Editor:—**How long is it safe for a couple to put off having children? Some of my confrères say that after three years the chance of barrenness is much greater.**

M.D., Kentucky.

ANSWER.—How long it is safe for a couple to put off having children will depend in large measure on the age of the wife. If she is in the early twenties, postponement of conception for three years or so would be generally safe. On the other hand, if she is 35 or over, it would not be safe; and even if she were 30 it would be unwise. The reason for this lies in the aging factor. Thus, the incidence of sterility due to such conditions as fibromas, endometriosis and ovarian dysfunction is greater at 35 than at 25 and increases slightly year by year after the latter age. Unpublished data, moreover, indicate that even in the absence of demonstrable pathologic lesions, the average time for conception to take place after marriage (no contraception being used) is longer in women in the thirties than in those in the twenties. This important problem is currently the subject of wide study, but publications covering the specific question cannot be cited at present.

SARCOIDOSIS

To the Editor:—**A 23 year old Czech who had inflammation of the lungs during military service without being confined to bed has had sarcoidosis pulmonum for over a year. The patient's illness is not getting better and his strength is decreasing. Medical examination of the lungs shows a tumorous condition in the lower part on both sides of the lungs, considered to be sarcoidosis pulmonum.**

M.D., Czechoslovakia.

ANSWER.—The cause of sarcoidosis is not known. The histopathologic aspects of the condition closely resemble those of noncaseating tuberculosis. The disease can involve almost any organ. It seems, however, to have a predilection for lymph nodes, skin, the pulmonary parenchyma, the spleen and the liver. It may also cause inflammatory changes in the eyes and the salivary glands. At times it will cause characteristic changes in the small bones of the hands.

Some workers feel that sarcoidosis represents a form of tuberculosis; others have argued against tuberculosis as an etiologic factor. This has led to some confusion. If lesions of the skin or enlarged peripheral lymph nodes are found, it is advisable to obtain a specimen for biopsy. A preferred method of performing such a study is to save half of an excised lymph node for microscopic study and the other half for culture or injection into guinea pigs. Needle biopsy of the liver has also been suggested for microscopic diagnosis when other methods of examination fail.

A patient may have bilaterally large hilar lymph nodes. At times the term "potato" lymph nodes has been given to these mediastinal nodes because of their size. An infiltration may be seen throughout the parenchyma of the lung which may resemble that usually seen in tuberculosis, and yet it may be impossible to find tubercle bacilli in the sputum or the gastric contents. More frequently, the infiltration involves the basal or midlung fields, with symmetric distribution, and at times there is a universally distributed fine nodular or floccuent lesion visible in roentgenograms of the thorax. Results of the single strength and second strength tuberculin tests should be negative. Possibly the outstanding clinical feature is that the patient may have extensive changes in the pulmonary parenchyma or the hilar lymph nodes and still appear to be well and to have few symptoms.

In general, the prognosis in sarcoidosis is good, but evidences of the disease usually persist for a few years. Deaths rarely have been attributed to the condition. At this time there is no medicine that is of definite value in sarcoidosis. Vitamin D and chaulmoogra oil have been tried by various investigators. Roentgen therapy has yielded equivocal results. Streptomycin has shown little promise. The most important phase of treatment is directed toward an adequate amount of rest. The lesion in the thorax should be observed by means of serial roentgenograms of the thorax under the supervision of the patient's physician, and, if progress is unfavorable, additional efforts to detect tubercle bacilli should be undertaken.

TREATMENT OF HICCOUGH

To the Editor:—**A 72 year old white widower, with long-standing severe pulmonary emphysema, cor pulmonale of a moderate degree, secondary polycythemia and mild benign prostatic hypertrophy, has bilateral indirect inguinal hernia the size of lemons. In the past, his abdomen has been entered on three occasions for the removal of appendix and gallbladder and repair of the abdominal wall from the resultant injury. He has had gradually increasing dyspnea for several years and episodes of mild cardiac decompensation, controlled by rest, oxygen and digitalis. Depending on his water balance and other unknown factors, his urine has occasionally shown small amounts of albumin, and his blood, moderate nitrogen retention. Carbon dioxide-combining power stays at about 100 volumes per cent. The degree of his cyanosis is startling. He has had hiccoughs intermittently since September 1947. Periodic at first, they are now almost constant. When they are at a minimum, he does fairly well, getting out to an occasional motion picture and for an automobile ride. When they are severe, he can only lie in bed at home in an oxygen tent. For the hiccoughs the following therapeutic efforts have been made: (1) all the old home remedies; (2) meperidine hydrochloride; (3) methadone; (4) atropine; (5) barbiturates; (6) paraldehyde; (7) ether; (8) alcohol; (9) oxygen by all routes of administration except intravenous; (10) bleeding to a hematocrit reading of 42 per cent; (11) mercurophylline administered intravenously and intramuscularly; (12) various expectorants; (13) aminophylline by all routes; (14) myanesin® (3-ortho-toloxy-1, 2-propanediol); (15) succinic acid administered intravenously; (16) ephedrine; (17) epinephrine; (18) antihistaminics; (19) autogenous vaccine, and (20) penicillin aerosol. Since his breathing reserve is so low and since both leaves of the diaphragm are involved, it has been felt that phrenic nerve interruption would be too dangerous. Because of his large hernias and the multiple previous laparotomies, pneumoperitoneum has been felt to be contraindicated. An abdominal belt was not of benefit. This patient's hiccoughs are literally killing him. Do you have any suggestions as to what might stop them?**

Christopher Parnall Jr., M.D., Rochester, N. Y.

ANSWER.—The great deterrent to treatment in this case is the very high carbon dioxide-combining power. The time-honored treatment of hiccough is carbon dioxide inhalations and lastly operation on the phrenic nerve. It is assumed that carbon dioxide was not used in this case because of the exceedingly high carbon dioxide-combining power.

A carbon dioxide-combining power of 100 volumes per cent is hard to explain, even in this case. One must assume that it does not represent true alkalosis because of the lack of other symptoms, unless one accepts the hiccough as evidence of alkalosis. Theoretically, it might be assumed that there is a large residue of carbon dioxide in the dead spaces of this emphysematous lung and that the large quantity of sodium bicarbonate is present to offset this material. Therefore it would do no great harm to give carbon dioxide inhalations together with oxygen. The only danger would be respiratory acidosis. The maneuver would have to be carefully carried out and the effects carefully observed. Oxygen with 5 or 10 per cent carbon dioxide would seem preferable.

Operation on the phrenic nerve should be seriously considered. Certainly the respiratory function is greatly reduced by the diaphragmatic spasm and it is doubtful whether it would be much further reduced by paralysis of one side of the diaphragm. Obviously the phrenic nerve should be crushed on the side in which the spasm occurs. At any rate if the hiccough is in fact killing the patient almost any procedure that offers even a slight hope is justified.

Lastly, the cause of the hiccough should be considered. Reflexes from the gastrointestinal tract might be reduced by full atropinization. Psychic causes should be considered, although psychotherapy in a patient 72 years of age does not offer much encouragement.

TUBERCULOSIS IN PREGNANCY

To the Editor:—**I am interested in comparing the effects of tuberculosis in pregnant women with the effects of coccidioidomycosis in pregnant women. Does the eventual outcome of tuberculosis have any correlation with the trimester of pregnancy in which the disease is diagnosed? Is there a higher incidence of miliary tuberculosis and/or tuberculous meningitis depending on the trimester that the disease is diagnosed, or is the incidence of these complications the same regardless of pregnancy?**

Hall Ramirez, M.D., Bakersfield, Calif.

ANSWER.—1. An accurate statistical answer is not available. In general, diagnosis in early pregnancy is desirable because it allows time for the institution of collapse therapy procedures. In late pregnancy it is often difficult to start such procedures and they are frequently deferred until delivery has taken place.

2. The entire question of the effect of pregnancy on tuberculosis is controversial, and widely divergent views have been expressed. It is generally held that patients do well during the period of pregnancy, but many show evidence of rapidly progressive disease during the postpartum months. The failure of these patients is held by some to be caused by a specific influence of pregnancy on tuberculosis; by some it is believed to be a mechanical effect due to the decompression of the chest at deliv-

ery, and a minority of observers deny that the course of the tuberculosis is influenced in any way by the pregnancy. Many studies of this problem have been attempted; the majority of clinicians conclude that pregnancy has a deleterious effect on tuberculosis; a few have the opposite opinion. Meningitis and miliary tuberculosis seem to occur more frequently among pregnant women, but no information is available indicating a greater tendency to occur in any particular trimester.

In contrast to the difficulty in analyzing resistance in tuberculosis, allergy can be measured easily. Quantitative tests (Lichtenstein, M. R.: Tuberculin Reaction in Tuberculosis During Pregnancy, *Am. Rev. Tuberc.* **46**:88, 1942) have demonstrated that allergy diminishes during the third trimester among tuberculous patients and returns to its former level soon after delivery.

MYELOID DEPRESSION FROM COPPER

To the Editor:—**Information is requested concerning myeloid depression following exposure to "corona 50 per cent plus" copper carbonate. A 57 year old farmer in excellent health used this product, mixing it with the wheat in a truck bed. In addition wind blew dust from the drill to the driver. The patient experienced a headache, hacking cough and a metallic taste in mouth, and later increasing weakness, substernal oppression on exertion and generalized purpura. Physical examination revealed no abnormality except for marked pallor. The red blood cell count was 1,940,000, the hemoglobin 6.4 Gm. per hundred cubic centimeters, white blood cell count 3,650, coagulation time 4 minutes, bleeding time 20 minutes; sedimentation rate 16 and clot retraction time 2½ hours. Since admission four days ago, with daily transfusions, the red blood cell count has risen to about 3,500,000 with the white blood cells remaining below 3,000. Sternal puncture revealed only mature red blood cells with occasional lymphocytes. The purpura has cleared up, bleeding time has returned to normal and a septic fever has developed. Is copper carbonate a known cause of primary refractory anemia?**

E. T. Cook, M.D., Anadarko, Okla.

[This inquiry was referred to two authorities, whose respective replies follow.—EDITOR.]

ANSWER.—Copper carbonate has never been reported as a cause of primary refractive anemia in man, nor is there any evidence from experimental work that copper in any form produces anemia. The only important evidence of disease in human beings resulting from exposure to copper salts is the allegation that it may be responsible for certain cases of hemochromatosis. This claim has never been generally accepted.

ANSWER.—Such heavy metals as arsenic, gold, bismuth and mercury are known to produce a refractory anemia. Reports could not be found of such an anemia following the administration of copper. Toxic doses of copper produce hemolytic anemia in animals (*Am. J. Path.* **7**: 351, 1931). Brodsky (*Arch. f. Gewerbepath. u. Gewerbehyg.* **5**:91, 1933) observed a variety of toxic symptoms in workers inhaling copper carbonate dust during the mixing with grain. The symptoms included fever, disagreeable taste in the mouth, nose bleeds, headache, cough, dyspnea and vomiting. No mention is made of changes in the blood picture. These persons recovered from the intoxication within a few days.

EXPANDED TONSILLECTOMY

To the Editor:—**What is present opinion concerning the desirability of an "expanded" tonsillectomy (Myersberg) as compared with the "usual type" in an average child in whom tonsillectomy is indicated? What are the advantages and dangers of each? What is the approximate frequency of use of each?**

M.D., New York.

ANSWER.—A well conducted tonsillectomy of the "usual type," which includes the separate removal of the tissue of a well developed plica triangularis and any fairly well developed lymphoid structures lying between the tonsil and the lateral aspects of the base of the tongue, will accomplish all that may reasonably be expected of this operation.

From written descriptions of the so-called expanded operation, there is no reason to believe that it is not equally effective if one wishes to learn the technic and acquire the armamentarium.

The advantages or dangers of one over the other do not appear sufficient to warrant a prejudiced attitude for carrying out one technic to the exclusion of the other.

It is practically impossible to state in accurate figures how many of the "expanded" tonsillectomies are being done. However, the number of the "usual type" must be vastly greater. The "expanded" type of operation in large parts of the country is practically unknown.

Examination of a number of relevant textbooks, all published in recent years, fails except in one instance to show a discussion of this "expanded" method. The exception is the work edited by Jackson and Coates, published in 1929.

SIALORRHEA

To the Editor:—**What is the effective treatment for persistent sialorrhea? The patient is 70 years old and has arteriosclerotic heart disease for which he receives digitalis daily. He has had bronchial asthma for thirty years and has had sialorrhea for the past five years. Sputum varies in consistency from watery to thick mucous.**

M.D., New York.

ANSWER.—Treatment of sialorrhea is aimed at the cause, and success depends on whether the cause can be found and a response is possible. There are many causes for salivation. Drugs, stomatitis, dental difficulties, vitamin B deficiencies, reflexes from the intestinal tract and other organs, psychic causes and organic disease of the central nervous system are among the most common ones. The patient's age and sex, the duration and persistence of the condition and the absence of notable digestive disorders would exclude a number of possibilities.

It is possible that the best diagnostic chance, based on the history, is that the chronic parasympatheticotonic (asthmatic) condition, in an arteriosclerotic man who could have a basal gangliar degeneration, has resulted in the sialosis. Stomatitis, smoking and avitaminosis could be contributing factors.

Atropine is the only drug of use, but its value may be limited by side effects. One could try it cautiously, giving 1/240 grain (about 0.25 mg.) after breakfast and lunch, doubling the dose if indicated, but being alert for toxicity. It probably would not be contraindicated by the cardiac condition and might help the asthma. The mouth should be cleaned up, and a vitamine B complex concentrate empirically given for several weeks. Irradiation of the salivary glands is known to decrease the flow, but often produces a dry mouth.

EXPOSURE TO OILS

To the Editor:—**For a considerable part of their working day, attendants at auto service stations and even more so men who clean out oil tankers inhale finely atomized petroleum oils. In view of the general warning against oily nose and throat sprays, are these men more afflicted with pulmonary disease such as tuberculosis, cancer and interstitial pneumonia than the general average? They never use respirators.**

Bernhard A. Fedde, M.D., Brooklyn.

ANSWER.—In addition to the occupations mentioned, many others involve continuous exposure to oils. In a limited number the sole employment centers about the spraying of metal parts with oils. At times the local atmosphere is laden with oily mists. Nevertheless, with the exception of dermatitis, the incidence of occupational diseases is low. In the case of dermatitis the offending agent is more likely to be some additive such as sulfur or chlorine. The well known "oil furunculosis" usually derives from no precise irritant but from inadequate skin cleanliness. Even in the absence of suitable inquiry it may be recognized that while the total number of scrotal and penile cancers may be low, the incidence is higher among the oil using trades of the United States. Pulmonary cancers from oils are so rare that a single case attracts attention. In other countries and notably the British Isles, cancer from oils is of more frequent occurrence. The "spinning jenny" cancers of the textile trades in the British Isles constitute a common occupational disease. This difference is attributed to the source of the oils. The Scottish shale oils are high in cancerigenic agents, as are some Balkan and Asiatic crudes. In the United States, the several oil fields differ as to base nature, but none is rich in cancerigens, although not wholly lacking in some. In part, the apparent rarity of pulmonary cancer among oil workers may be due to lack of suitable investigation. In any circumstance, increased numbers may shortly be expected, since it is only a question of time until shale oils and fuels will be produced in this country together with increased dependence on oil imports with their higher cancerigenic content. All such items are ably presented by Hueper in his "Occupational Tumors" (Springfield, Ill., Charles C Thomas, Publisher, 1942).

ANEMIA IN X-RAY DEPARTMENT PERSONNEL

To the Editor:—**I look after the health of a hospital staff. Some persons working in the x-ray department have anemia, normocytic and normochromic in type. What preventive measures should be taken, and what treatment do you suggest?**

M.D., Canada.

ANSWER.—This is evidently a group of persons who have anemia, but whose red blood cells are normal in size and the color index is 1. If the normocytic, normochromic anemia was the result of exposure to roentgen rays it would be an advanced symptom (tendency to hypoplastic or aplastic anemia or "refractory anemia") and would be associated with a decrease in the

number of white blood cells and platelets. If these are not decreased in number, it may be associated with nephropathy or there may be a hemolytic factor. Normocytic anemias are sometimes noted in certain endocrine deficiencies, but it is not probable that a group of persons would be affected at the same time. Chronic infections are more frequently associated with a hemoglobin deficiency type of anemia (hypochromic). If a vacation of four weeks, away from the x-ray department, is not followed by improvement, the susceptible persons ought to avoid the possibility of damage to the blood-forming organs by further exposure to roentgen rays. Presumably there is no iron or liver extract deficiency, so that theoretically there would be no indication for these medicines. If a dilution factor could be demonstrated in the blood, a higher intake of protein could be tried.

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MYELOGENOUS LEUKEMIA

To the Editor:—**A Puerto Rican male, 43 years old, complained of abdominal discomfort. His history was noncontributory and tropical diseases were denied. Examination showed the spleen extending almost to the navel. Other clinical findings were normal. The blood cell count revealed 12.5 Gm. hemoglobin per hundred cubic centimeters, 4,940,000 erythrocytes and 2,800 leukocytes, with 54 per cent segmented cells, 38 per cent lymphocytes, 4 per cent band cells, 1 per cent metamyelocytes and 3 per cent eosinophils; there was moderate anisocytosis and poikilocytosis. Malarial parasites were not seen on smear. The urine was amber, cloudy and acid in reaction; there was insufficient quantity to observe specific gravity; tests for sugar and albumin were negative in result; many mucus threads and occasional epithelium were observed on microscopic examination. The Wassermann reaction was negative. A sternal puncture was performed, and the pathologist reported that the finding was compatible with myelogenous leukemia. Diagnosis was subleukemic leukemia. The general condition of the patient was not bad; he is weak, has lost weight and is unable to do manual work. Is splenectomy indicated, or should I continue with arsenic and vitamins? Is a different treatment indicated?**

Stephen F. Saxl, M.D., New York.

ANSWER.—The answer to this question depends, in part, on the accuracy of the pathologist's conclusion that the findings were compatible with those of myelogenous leukemia. That, certainly, is a plausible diagnosis as judged by the limited information given. If this is the correct diagnosis, splenectomy is not indicated. Such an operation is not likely to do good and carries a substantial risk operatively and postoperatively.

Assuming that the diagnosis is myelogenous leukemia in a subleukemic stage, urethane, roentgen irradiation or even nitrogen mustard may be considered as well as arsenic, in selecting a therapeutic agent. However, if the patient does not have complaints at this time, nothing need be done. If the abdominal tumor becomes troublesome of itself, local irradiation may be helpful. Vitamins are not indicated. In fact, there is some evidence that folic acid may actually aggravate leukemia.

DIETHYLSTILBESTROL IN ENDOMETRIOSIS

To the Editor:—**What is the dose of diethylstilbestrol that will suppress menstruation in a case of suspected endometriosis? Is such a trial advisable?**

M.D., Massachusetts.

ANSWER.—The dose of diethylstilbestrol which will suppress menstruation (with or without endometriosis) varies with the patient. The bigger the dose the better and the quicker it suppresses the period, but, unfortunately, in many women nausea and vomiting prevent the larger dosage. Giving diethylstilbestrol just as the patient goes to bed prevents some of the nausea. One can start with a 5 mg. dose and increase it each night by one tablet (5 mg.) until 25 mg. a day is being taken, stopping when nausea becomes severe, or one can start with 25 mg. each night, reducing it 5 mg. each night if nausea supervenes. The latter method seems to work faster.

The second question can only be answered by saying that we do not know whether it will suppress endometriosis or whether it is advisable. We do know that the small doses produced by the normally menstruating ovary make endometriosis worse or cause it to progress. Whether the stimulating effect of large doses of estrogen on the endometrial-like tissue is greater than the ovulation-suppressing effect of the large doses is not at present fully known.

ETIOLOGY OF URINARY CALCULI

To the Editor:—**A 30 year old white man was stationed with the Air Force in Accra, British West Africa, during the war. Since returning home he has had four severe attacks of renal colic. Each time a stone was passed, an analysis of one of the stones showed it to be a calcium compound. He has been on a low calcium diet, which was recommended by a urologist, but has continued to form stones. The patient tells me that renal stone formation amongst the native population of Accra is common, many dying from complications. The patient's past history and his family history are noncontributory. Is it possible that ingestion of the water of Accra (the source of trouble in the natives) has influenced the chemical process of the body so that he will continue to form stones? Have similar cases been reported?**

M.D., Massachusetts

ANSWER.—The etiology of urinary calculi is complex and includes factors of infection, stasis or obstruction, deficiency diets, excessive excretion of calcium due to various causes for mobilization of calcium from the bones or, more rarely, to excessive oral intake. In addition there are probably constitutional predisposing factors in some instances. The high incidence of renal stone formation among natives in India, Africa and other poverty stricken areas is undoubtedly related to severe dietary deficiency. In hot climates where the water supply is poor, stones may develop within weeks or months if the subject neglects to maintain a sufficiently large fluid intake. This was demonstrated in Army experiences during the recent war. If, in such circumstances, immobilization occurs as a result of illness, or if the ration contains considerable calcium, precipitation in the urinary tract can easily occur. The ingestion of the local water would be an aggravating factor only if it happened to contain a large amount of calcium. This influence would cease, however, with departure from the particular region.

The continued formation of urinary calculi in a patient must therefore be ascribed to one or more of the other factors listed. It is assumed that a careful study of the urinary tract has been made to exclude stasis and infection. Dietary treatment is not successful although, if the stone consists of calcium oxalate, foods containing large amounts of oxalate such as chocolate, beets, spinach, rhubarb and Swiss chard should be eliminated from the diet. Intake of milk and cheese should also be restricted. The most important item, however, is the large fluid intake, enough to produce at least 3 liters of urine daily. Hyperparathyroidism should be excluded by appropriate tests.

Reference:

Pierce, L. W., and Bloom, B.: J. Urol. **54**: 466, 1945.

GALACTORRHEA

To the Editor:—**A 30 year old white married woman has 1 child, aged 2½. In November 1948 the patient noticed the sudden onset of bilateral lactation without apparent cause. She feels fine otherwise. She is not pregnant and her menstrual periods are completely normal. Pelvic examination was negative. Examination of the breasts by palpation and transillumination did not reveal abnormality. There has been little or no manipulatory stimulation of the breasts. The patient is completely feminine in appearance without outward signs of glandular dysfunction. In October 1948, one month prior to the onset of the lactation, the patient had an attack of herpes zoster involving the five lower intercostal spaces and ribs as well as the back on the right side. The skin lesions have disappeared, although some burning and pruritus remain over the involved area. Since the abnormal lactation began, she has received the following medication without apparent effect: (1) testosterone, 5 mg. daily for seven weeks; (2) diethylstilbesrol, 10 mg. daily for four weeks; (3) diethylstilbestrol and testosterone, 5 mg. daily of each for four weeks. These medicaments were administered for approximately twenty-three days of each menstrual cycle and were omitted during the period itself. Despite the treatment, lactation has continued without interruption and recently has been increasing in quantity. The breasts are painful and the apparently normal milk is expressed with the slightest pressure. There have not been other signs of abnormal secretion. 1. What are the causes for this condition? 2. Are any further laboratory measures indicated? 3. What therapeutic measures might terminate the secretion? 4. Is there any known relationship between shingles and "idiopathic lactation"?**

David L. Cronin, M.D., Reseda, Calif.

ANSWER.—1. This condition called galactorrhea may be due to a variety of conditions including atrophy of the uterus and ovaries, neoplasms of the pituitary gland or midbrain structures, rare diseases of the brain and shock to the nervous system. The mechanism involved in galactorrhea is not understood. 2. There are no specific laboratory tests to be performed, but every effort must be made to be sure there is no pituitary or other brain disturbance, neoplastic or otherwise. 3. Treatment is unsatisfactory. However, it is recommended that 10 mg. diethylstilbestrol be continued daily for at least three months, and if necessary even up to six months. Roentgen therapy applied directly to the breasts may suppress the secretion of milk but is not advisable in a woman only 30 years of age.

Likewise, radiation treatment to the pituitary gland may stop the flow of milk, but this treatment also may not be harmless; hence, more time should be permitted to elapse to see what further estrogen treatment will do. 4. There is no apparent connection between herpes zoster and galactorrhea.

PULMONARY EMBOLISM IN HEMIPLEGIA

To the Editor:—A 19 year old sailor was observed to have subacute bacterial or acute bacterial endocarditis, embolic phenomena, fever, enlarged spleen and roughened mitral murmur in systole. Six cultures were negative and therapy was withheld for three days. Treatment with progressively increasing doses of penicillin was instituted, up to 10,000,000 units daily, before fever was controlled in the face of increasing symptoms. On the eighth day of therapy, which consisted of intravenous drip during the day and intramuscular drip during the night, gradually occurring hemiplegia of the right forearm and hand developed, and he remained in near coma for five days. He regained full mental capacity and clear speech after two weeks. Passive movements and massage on the paralyzed leg were begun within three days after the cerebral accident. Repeated circulation times were normal. What appeared to be three pulmonary emboli developed. The first was not recognized, but the two later ones two days afterward at about two hour intervals were characterized by dyspnea, substernal pain, a sense of impending disaster and confusion and perspiration. Penicillin was increased to 20,000,000 units by continuous intravenous route, and administration of heparin was begun immediately, with an eventual change to dicumarol.® The patient is alive and afebrile after three months. 1. How frequent are pulmonary emboli in cases of hemiplegia in young subjects with previously normal veins? 2. Is venous insufficiency any more frequent when ligation is performed in the presence of paralysis and sensory loss in the leg? 3. In view of the frequent reports of cerebral hemorrhage occurring in patients treated with anticoagulants was a venous ligation to be preferred after the initial attack had subsided?

F. E. Wetzel, M.D., San Francisco.

ANSWER.—Pulmonary embolism has occurred rarely in patients who have had hemiplegia irrespective of their age. The venous system probably would not become insufficient after ligation in the presence of paralysis and sensory loss in the leg. The collateral circulation is so good in young persons that the effect of it on the normal venous circulation would hardly be detectable, providing the interruption was distal to the profunda femoris vein or to the saphenofemoral junction. In any patient who has had a pulmonary embolism that is nonlethal, the best method of treatment, providing a competent vascular surgeon is available, is to interrupt the femoral veins in both groins. These interruptions should be just distal to the saphenous vein; if a thrombus is found in the femoral vein, a thrombectomy may be done at the same time. In summary, the safest method of treatment in competent hands for your patient probably would have been interruption of both femoral veins. Further experience with the anticoagulants is still necessary to determine whether this method of therapy is as satisfactory as interruption of the femoral vein in the presence of recognizable venous thrombosis and pulmonary embolism.

EXPOSURE TO CHLORINE AND HEART DISEASE

To the Editor:—A 41 year old white man has complained of shortness of breath and nonproductive cough for one year. He states that he was in good health until exposed to an unusually heavy concentration of chlorine gas while at work. Immediately after this exposure he was hospitalized four days with acute respiratory symptoms. He has had profuse night sweats for several months and reports a weight loss of 24 pounds (10.9 Kg.) in one year. He has previously been digitalized and has received weekly injections of a mercurial diuretic. On examination, the man appeared acutely ill with moist rales scattered through both lung bases. The heart was grossly enlarged with a definite apical thrust both visible and palpable in the midaxillary line. Significant murmurs or thrills were absent. The blood pressure was 166 systolic and 116 diastolic. Strong femoral pulsations were felt bilaterally. The liver was not enlarged and there was no dependent edema in the ankles. Films and fluoroscopy of the chest showed a typical water bottle shape, increased in all diameters. Evidence of pulmonary tuberculosis was lacking. Blood count showed moderate hypochromic anemia with a total white cell count of 12,700 with 85 per cent polymorphonuclear cells and 15 per cent lymphocytes. Urinalysis revealed a trace of albumin and a few hyalin and finely granular casts. The sputum contained blood, but smears and cultures were negative for tubercle bacilli. A blood culture was negative. While the roentgen observations are suggestive of pericardial effusion, the blood pressure and loudness of the heart sounds on auscultation and the prominence of the apex beat tend to support the probability of a severe hypertensive cardiac disease with cardiac dilatation. Are any reports available indicating that cardiac dilatation and chronic failure may result either in a normal or previously damaged heart from exposure to chlorine?

Donald N. Fewell, M.D., Stockton, Calif.

ANSWER.—The problem of a possible relationship of exposure to chlorine gas with respiratory symptoms and cardiac failure is difficult to evaluate in this case. The presence of hypertension and enlargement of the heart to the left and right suggest that cardiac failure might be on the basis of hypertension alone. However, the development of cor pulmonale secondary to pulmonary fibrosis resulting from chlorine inhalation cannot be excluded with the data presented. The electrocardiogram and pulmonary physiologic studies, if compensation could be effected, would be helpful. A survey of recent literature fails to reveal documented cases of heart failure secondary to the inhalation of noxious gases. Acute pulmonary edema is not unusual and responds to positive pressure administration of oxygen. However, Winternitz and his co-workers have produced pulmonary fibrosis in experimental animals following inhalation of irritating substances.

TREATMENT OF TRIGEMINAL NEURALGIA

To the Editor:—During the past year I have treated successfully 3 cases of trigeminal neuralgia with repeated injections of vitamin B complex. Since all the books still consider it a purely surgical problem I would greatly appreciate your comment.

Edmund Fremont, M.D., Manite, Ill.

ANSWER.—This is an old story. Trigeminal neuralgia can be temporarily successfully treated with any form of therapy as it is a characteristic of the disease that it subsides spontaneously. When it is the first attack of the disease which is so treated the results are apt to be particularly gratifying, as the freedom from further difficulty, after the first attack has subsided, often persists for two or three years regardless of the type of treatment. However, when the pain returns the treatment which originally proved so successful, whether it be vitamin B complex or some other type of medical therapy, practically never succeeds again. Only injection of the nerve with alcohol, section of one of the peripheral divisions or of the sensory root back of the gasserian ganglion can be relied on to relieve the pain of this disease with certainty, but only section of the root back of the ganglion will give permanent relief. The use of vitamin B in the treatment of trigeminal neuralgia has often been recommended, and there are numerous publications dealing with this form of treatment. It is unfortunate that it is not effective.

HIGH INTENSITY SOUND WAVES IN AVIATION

To the Editor:—Pilots have inquired of me of the possible effect of "high frequency" and "high intensity" sounds and vibrations on the production of fatigue. I quote from a pilot's letter: "It is felt that the sounds and vibrations we are worrying about are those not heard by the human ear, and possibly the vibrations are so high in frequency that they are not felt by the human body. For example, there is a dog call whistle which cannot be heard by human beings, but will attract the attention of a dog at a considerable distance. We believe that such sounds and vibrations come from propellors or slipstream hitting along various windshield corners or other irregularities on the fuselage or other parts of high speed aircraft." I am unable to find any information on "sounds unheard" and "vibrations not felt" by the human body.

Herbert F. Fenwick, M.D., Chicago.

ANSWER.—Clinical or experimental evidence to indicate that sound waves above the frequency range audible to the human ear can produce auditory fatigue or acoustic trauma has not been reported. Extremely high intensities of these so-called supersonic sound waves at close range can cause tissue destruction by the production of heat. However, the intensity of sound generated around the moving parts of an airplane would be much below this intensity level.

It is a safe rule that "what the ear cannot hear will not harm it."

TOXICITY OF PIPE-SEALING COMPOUNDS

To the Editor:—Does Leadite,® manufactured in Philadelphia, contain toxic material that would produce anemia and nephritis?

Fred Pulgram, M.D., Trenton, Ill.

ANSWER.—This product, manufactured by the Leadite Company, Inc., Girard Trust Company Building, Philadelphia, is believed to represent a pipe joint sealer. Since there are scores of compounds of this nature, the reply made is general rather than specific. Ordinarily, these substances fall into two groups; those that contain lead and those that do not. Frequently, the non-lead-bearing agents are promoted as containing no poisonous substances and represent various mixtures of Portland cement, flour, tar, talc and lampblack. The leaded types are usually made in paste form and involve mixtures of divers lead compounds in oils and glycerin. Theoretically, any and all of these compounds are applied only on the exterior of joint surfaces for sealing purposes, but some is likely to come in contact with the interior of pipes at the joint areas. This exposure might be the source of lead poisoning, particularly in large new housing projects where all piping is new. Actual tests as carried out by the Detroit Department of Health

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reveal no significant lead content in water. Such lead as appears shows up as "slugs" of such size as likely to attract attention and is discarded. The remote possibility remains that lead poisoning may arise from this source from the intake of a few small "slugs" of this leaded paste. The manufacture of these preparations, starting with dusty lead compounds, may constitute an industrial exposure. Considerable lead intake from any of these pipe joint compounds would cause lead poisoning. Anemia and nephritis might then arise, along with other indications of plumbism.

TREATMENT FOR ENLARGED THYMUS

To the Editor:—**A 10 month old male infant is in excellent condition except for an enlarged thymus gland. The first roentgenogram showed a borderline case of enlargement; two others, and roentgenograms taken since that time, also show it to be enlarged. He has had five roentgen treatments and now the roentgenologist suggests high voltage roentgen therapy or surgical removal. What do you consider the best treatment for this patient? Are there dangers in roentgen therapy?** M.D., Pennsylvania.

ANSWER.—A 10 month old male infant in excellent physical condition might be expected to have a relatively large thymus gland. The only evidence of its enlargement, according to the query, was in two roentgen examinations. Most authors question the validity of an anterior-posterior roentgen measurement as being diagnostic of an enlarged thymus gland. Other causes for a widened supracardiac shadow in the roentgenograms are tracheobronchial lymphadenitis, mediastinal pleurisy, paravertebral abscess, mediastinal neoplasms, pulmonary atelectasis and consolidation.

Other authors disregard the transverse shadow and have attempted to demonstrate by lateral technic a thickened thymus gland which might encroach on the trachea. In a series of careful studies by this method over 50 per cent of normal infants seem to show a narrowing of the tracheal lumen.

As the thymus gland is composed of lymphatic tissue, rather sensitive to roentgen irradiation, it would seem that the five roentgen treatments should be more than adequate, particularly in view of the fact that the infant is entirely asymptomatic, and the only criteria for enlarged thymus in his case are the roentgen examinations. High voltage roentgen therapy might be dangerous, as there are other organs more vital to life in the region of the anterior mediastinum than the thymus gland. As a general rule, it may be stated that heavy roentgen dose is contraindicated and it would be much better to undertreat than overtreat with roentgen therapy.

There is absolutely no indication for surgical removal in a physically normal child who has shown no symptoms.

DINITROPHENOL AND FORMATION OF CATARACTS

To the Editor:—**I am much interested in the actions of dinitrophenol and its relation to the formation of cataracts. Has anyone been able to say definitely what toxic condition has been responsible for producing cataracts and what degenerative changes may occur as a result, not only in the lens of the eye but in the body?** J. O. Chiapella, M.D., Chico, Calif.

ANSWER.—Dinitrophenol increases cellular metabolism primarily at the expense of fats and carbohydrates. A large number of clinical and experimental studies have not indicated the cause of the cataract formation. Horner (Dinitrophenol and Its Relation to Formation of Cataract, *Arch. Ophth.* **27**:1097, 1942) found only 0.86 per cent of all persons who ingested dinitrophenol afflicted with cataract. No correlation to the amount of drug taken, or to the length of time during which it was taken, or to the age of the patient could be established. Females may be more susceptible than males, and there is apparently a genetic susceptibility to cataract formation due to the drug. The usual laboratory animals are immune, but in baby chicks and baby ducks acute reversible lens opacities develop within a few hours after administration. The only characteristic lesions caused by the compound are bilateral progressive cataracts. Dermatitis, agranulocytosis, peripheral neuritis and hepatic, renal and cardiac damage have been described.

Buschke (Acute Reversible Cataract in Chickens Due to Various Nitro Compounds, *Am. J. Ophth.* **30**:1356, 1947) found a close correlation between cataract-producing properties of nitro compounds and ability to raise the basal metabolism of the animal. He postulated that a disturbance of the phosphorylative mechanism of the lens might cause dissipation of energy necessary to specific tissue functions and might result in cataract formation.

SWEET TASTE SENSATION

To the Editor:—**A middle-aged man is complaining of a strong, sweet taste in the mouth which at times becomes unbearable. He has had it constantly for three months. History and physical examination are negative. Please advise.** H. J. Konstam, M.D., New York.

ANSWER.—The complaint of a constant, strong, sweet taste by a middle-aged man who does not show abnormal conditions may be due to the actual presence of a sweet-tasting material, to a neurogenic cause or to a psychoneurotic aberration. A sweet taste may arise from infection in the respiratory tract or mouth, or from a denture or wash, but it is unlikely that it would be as intense as described, and the taste from such causes is more commonly sour, bitter or foul. It is also improbable that it could be caused by a nerve lesion, and a central lesion in the temperosphenoid lobe usually produces fleeting hallucinations.

If a local cause can be excluded by a reexamination, the patient should be examined by a neuropsychiatrist. Hysteria, although usually showing multiple symptoms and obviously based on a suggestive background, can produce a constant, intense taste perversion—a conversion symptom based on a suppressed wish. A history of some change or stress or illness at the time of onset might be significant.

EFFECT OF ROENTGEN TREATMENT ON BRAIN TISSUE

To the Editor:—**Is anything known about the effect of intensive roentgen treatment on normal brain tissue?** M.D., Pennsylvania.

ANSWER.—Nervous tissue, both of the central nervous system and the peripheral nerves, is notoriously resistant to the effects of irradiation. However, in those instances in which enormous doses of radiation have been given or in which moderate treatment has been repeated at intervals so that there is a large cumulative total dose, fibrosis (gliosis) has been noted and subsequent gross atrophy and shrinkage of the irradiated brain observed. With the ordinary large dose treatments not repeated too often, one can say that normal brain tissue is unaffected.

ELECTROGALVANIC CURRENTS FROM DENTAL FILLINGS

To the Editor:—**How can one determine and rule out burning sensation of the tongue due to electrogalvanic currents in the mouth as a result of metal fillings?** William L. Dobes, M.D., Atlanta, Ga.

ANSWER.—One can determine the importance of electrogalvanic currents from fillings of different potential by indirect and direct means. 1. Be sure that another cause for the glossopyrosis is not present, such as glossitis, a deficiency (notably B complex), the use of an irritant (tobacco, a mouth wash, food or drink), an estrogenic deficiency, a deficiency of saliva, cancerophobia, a neurogenic or psychogenic source. 2. Burning from an electrical source is not common, and it occurs soon after dental repair. The sequence is usually obvious. 3. Removal of the guilty filling or denture and replacement by a temporary nonmetal filling is a direct therapeutic test which should be done only if indicated by the findings of numbers 1 and 2.

Some oral specialists feel that all forms of glossitis should be given therapy with a vitamin B complex concentrate. This is probably legitimate only when another specific cause cannot be found.

TUBERCULIN REACTION AND ANTIHISTAMINICS

To the Editor:—**What is the effect of antihistaminic drugs on the tuberculin skin reaction? Is it possible for a person with a positive reaction to tuberculin to obtain a negative skin reaction to tuberculin or to purified protein derivative of tuberculin by taking antihistaminic drugs prior to and during tuberculin skin testing? References, if any, will be appreciated.** M.D., New York.

ANSWER.—There is a difference in opinion on this subject. However, trustworthy reports indicate that antihistaminic drugs do not modify the intradermal reaction or other manifestations of tuberculin allergy. The Koch phenomenon and tuberculin shock in tuberculous guinea pigs apparently persist in spite of previous injection of histamine. Articles on this subject which may be consulted are: Boquet, A.: *Annales de l'Institut Pasteur*, **69**:55, 1943, and Kreis, B.: *ibid.* **72**:308, 1946. Unpublished experiments in which tuberculous guinea pigs were given large injections of antihistamine and then tested with tuberculin indicate that significant modification of the tuberculin skin reaction did not result from the antihistamine injection.

GALACTOSE TOLERANCE

To the Editor:—Is galactose used in sugar tolerance tests? Is it in any way superior to the use of dextrose?

Frederick Falkson, M.D., Waldan, N. Y.

ANSWER.—The usual "sugar tolerance test" employs dextrose. It has clinical value in diabetes mellitus, renal glycosuria and in certain other conditions. Perhaps what is meant is the galactose tolerance test, or Bauer's test, which indicates the carbohydrate tolerance of the liver. This latter test is not very reliable, but if carried out properly it may be of value in the differential diagnosis of hepatic dysfunction. Galactose, like dextrose, is a simple sugar which is available in pure form. It is assimilated and converted into glycogen by the liver. It differs from dextrose, however, in that the rest of the body seems unable to store galactose and it is not a "renal threshold substance." Any good textbook on laboratory methods in clinical diagnosis discusses both of these tests.

DEATH IN TERTIAN MALARIA

To the Editor:—A 25 year old white veteran had severe chills, high grade fever and malaise of two days' duration. A blood film showed ring forms of the tertian malarial parasite. Quinacrine hydrochloride was prescribed in 0.1 Gm. doses; after he had taken four tablets he became disoriented and shortly after lapsed into a deep coma and became incontinent of stool and urine. The patient was hospitalized and died two hours after arrival. Just prior to death the temperature was 104 F. (rectally), and a diffuse macular rash and a few petechial areas appeared on the abdomen. Necropsy was not performed. Could this have been a case of cerebral malaria? The blood film showed tertian parasites only. Was this a case of adrenal disease of the Waterhouse-Friderichsen type?

N. W. Nemiroff, M.D., Oradell, N. J.

ANSWER.—As a rule cerebral malaria does not occur with vivax (tertian) malaria. It is possible to have convulsions in recurrent malaria of the vivax type, with hyperthermia. It would be doubtful if the rapid death occurred as the result of the quinacrine, which probably had been taken on many previous occasions without similar effects. It would seem doubtful that this is a case of adrenal gland disease of the Waterhouse-Friderichsen type from the available evidence.

INTRAVENOUS THIAMINE AND PYRIDOXINE

To the Editor:—What is the maximum dose of thiamine hydrochloride and pyridoxine permitted intravenously to a female patient suffering from toxemia caused by pregnancy? A colleague has suggested 200 mg. of each at the same time. I feel that this amount would endanger the liver of the patient.

Fred F. Prausnitz, M.D., Larchmont, N. Y.

ANSWER.—Thiamine hydrochloride can be toxic and probably not more than 50 mg. should be given intravenously. In one case 100 mg. produced complete collapse. Some authorities say that only 1 to 2 mg. is utilized daily; if this is true, large doses are unnecessary. The oral route seems to be as good as any other unless vomiting prevents it. As for pyridoxine, much less is known about it and the dosage has not been completely established.

The many preparations of vitamin B in which the various elements are given in their known amounts according to present day knowledge are much better to use orally. If the patient is vomiting, they can be given intramuscularly.

The value of using large amounts of thiamine or pyridoxine in toxemia of pregnancy has not been proved.

TUBERCULIN SKIN TEST

To the Editor:—How long after onset of infection does it take a patient with skin tuberculosis to acquire sensitivity (allergy) so that it can be detected by the usual tuberculin skin tests?

Edward S. King, M.D., Winston-Salem, N. C.

ANSWER.—The most reliable data come from the vast experience of the last few years with intracutaneous injection of BCG vaccine. Since the organism used in this vaccine is a live bacillus and inoculation sets up a true, even though abortive infection, data from vaccination experiments would seem to answer the question most satisfactorily. Experience has shown that after administration of 0.1 mg. BCG vaccine, the tuberculin skin reaction becomes positive during the third week. Tests at the end of three weeks generally elicit positive reactions to 0.1 mg. old tuberculin, although the reaction is ordinarily not a strong one. Probably the results of this controlled observation in vaccinated persons can be applied in estimating the time of development of skin allergy after accidental skin infection with tubercle bacilli in man.

HUMAN FERTILIZATION BY ANIMALS

To the Editor:—Is there any truth to stories that women can be bred and conceive by animals? Can men breed with female animals?

M.D., Illinois.

ANSWER.—Mating of human beings with animals is physiologically impossible; hence, there is absolutely no basis for the stories that pregnancy can result from such matings. No one has even attempted to bring forth proof of such an occurrence.

TREATMENT OF ARTERIOSCLEROSIS

To the Editor:—What is the present status of the use of choline and inositol in the treatment of arteriosclerosis?

Maurice Goleburn, M.D., Wilmington, Del.

ANSWER.—Dr. Lester Morrison of the College of Medical Evangelists has reported that choline appears to have a slight favorable effect on cholesterol-induced arteriosclerosis in rabbits. No report of the use of choline in human arteriosclerosis has been found in the recent medical literature. This is also true for inositol.

The evidence for the role of cholesterol in the production of human arteriosclerosis is equivocal and there is no evidence that the feeding of choline or inositol will alter significantly the blood cholesterol levels in normal or arteriosclerotic animals or human beings.

CHILDREN'S SHOES

To the Editor:—At what stage should an infant wear shoes? Is there any advantage in the high shoe as compared with the oxford at any stage of development? Is there any advantage to the type of shoe in which the sole continues up the back of the shoe (Jumping Jacks) in the normally developing foot?

Milton Marcus, M.D., New York.

ANSWER.—1. Shoes need not be put on infant's feet until they stand and walk on hard surfaces. When children start to walk and the surfaces are soft (sandpiles, grass, play pen pads) they should be allowed to walk barefoot. This will permit normal development of the foot. 2. The infant's first walking shoe should be firm soled with a rigid counter and adequate support for the arches. Most observers believe that the first shoes should be high topped, to provide ankle support. After the child has learned to walk either high shoes or oxfords are acceptable. 3. The continuation of the sole up the back merely serves as a firm counter.

OIL-ANESTHETIC MIXTURES

To the Editor:—Is it safe to inject one of the oil-anesthetic mixtures into the pericoccygeal tissues for relief of coccydynia? Have any of the oil-anesthetic mixtures been used for paravertebral lumbar sympathetic blocks? Are there any authentic cases on record of oil embolism (pulmonary) following the use of anesthetic-in-oil mixtures?

Paul Russell, M.D., Inglewood, Calif.

ANSWER.—Anesthetic-in-oil mixtures are used for the relief of chronic pain. These mixtures, for the most part, contain procaine and benzyl alcohol in a peanut oil base. They are most useful when pooled about a nerve trunk. The infiltration into tissues with this material, especially if the tissue is superficial, does not seem advisable because of the danger of sloughing. Anesthetic-oil mixtures have been used for paravertebral lumbar sympathetic blocks. It would be extremely unlikely for oil embolism to occur after use of these mixtures provided the proper technic of injection is followed. One must be sure to aspirate frequently to avoid intravascular injection.

INSULIN IN INOPERABLE CANCER

To the Editor:—I am treating a man with inoperable carcinoma of the descending colon, who is still able to continue his business most of the time. Because of loss of weight and vomiting in the presence of minimal pain, the question has come up whether insulin for malnutrition would conceivably stimulate the progress of the tumor. Is there a contraindication to giving insulin for undernourished persons with early duodenal ulcer?

M.D., Virginia.

ANSWER.—The use of insulin to stimulate a gain in weight has had wide favor, and at times has seemed to be effective. Insulin is not known to stimulate the growth of cancer. Insulin in small doses (5 units) may be used to stimulate the appetite of undernourished patients who have duodenal ulcer. Use of doses large enough to produce hypoglycemia should be avoided because of the stimulating effect of hypoglycemia on gastric secretion.

JOURNALS ABSTRACTED IN THE CURRENT MEDICAL LITERATURE DEPARTMENT, MAY—AUGUST 1949

Titles have been listed or abstracts made of important articles in the following journals in the Current Literature Department of THE JOURNAL during the past four months. Any of the journals, except those starred, will be lent by THE JOURNAL to subscribers in continental United States and Canada and to members of the American Medical Association for a period not exceeding three days. Three journals may be borrowed at a time. No journals are available prior to 1938. Requests for periodicals should be addressed to the Library of the American Medical Association and should be accompanied by stamps to cover postage (6 cents if one and 18 cents if three periodicals are requested). Thus most of these journals are accessible to the general practitioner.

Acta chirurgica Scandinavica. Stockholm.
Acta clinica belgica. Brussels.
Acta dermato-venereologica. Stockholm.
Acta haematologica. Basel.
Acta medica orientalia. Jerusalem
Acta medica scandinavica. Stockholm.
Acta ophthalmologica. Copenhagen.
Acta orthopaedica Scandinavica. Copenhagen.
Acta oto-laryngologica. Stockholm.
Acta paediatrica. Stockholm.
Acta radiologica. Stockholm.
American Heart Journal. St. Louis.
American Journal of Clinical Pathology. Baltimore.
American Journal of Digestive Diseases. Fort Wayne, Ind.
*American Journal of Diseases of Children. A. M. A., Chicago.
American Journal of Hygiene. Baltimore.
American Journal of the Medical Sciences. Philadelphia.
American Journal of Medicine. New York.
American Journal of Obstetrics and Gynecology. St. Louis.
American Journal of Ophthalmology. Chicago.
American Journal of Orthopsychiatry. New York.
American Journal of Pathology. Ann Arbor, Mich.
American Journal of Physiology. Baltimore.
American Journal of Psychiatry. New York.
American Journal of Public Health. New York.
American Journal of Roentgenol. and Radium Therapy. Springfield, Ill.
American Journal of Surgery. New York.
American Journal of Syphilis, Gonor. and Venereal Diseases. St. Louis.
American Journal of Tropical Medicine. Baltimore.
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The letters used to explain in which department the matter indexed appears are as follows: "BI," Bureau of Investigation; "E," Editorial; "C," Correspondence; "OS," Organization Section; "ab," abstracts; the star (*) indicates an original article in THE JOURNAL.

This is a subject index and one should, therefore, look for the subject word, with the following exceptions: "Book Notices," "Deaths," "Medicolegal Abstracts" and "Societies" are indexed under these titles at the end of the letters "B," "D," "M," and "S." Matter pertaining to the Association is indexed under "American Medical Association." The name of the author, in brackets, follows the subject entry.

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Acad.—Academy *Indust.—Industrial*
Am.—American *Inst.—Institute*
A.—Association *Internat.—International*
Coll.—College *M.—Medical*
Comm.—Commission *Med.—Medicine*
Comm.—Committee *Nat.—National*
Conf.—Conference *Pharm.—Pharmaceutical*
Cong.—Congress *Phys.—Physicians*
Dist.—District *Soc.—Society*
Div.—Division *Surg.—Surgery*
Found.—Foundation *Surgs.—Surgeons*
Hosp.—Hospital *S.—Surgical*

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In this Index are the names of the authors of articles which have appeared in THE JOURNAL, the names of those who have read papers before Societies as published in THE JOURNAL and those whose articles have been abstracted in the Current Medical Literature Department. The * preceding the page reference indicates that the article appeared in full in THE JOURNAL.

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